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ABSTRACT

This hearing presents testimony on Medicare support for graduate medical education in light of Clinton Administration and other reform proposals to reduce the number of specialized residencies in teaching hospitals. The testimony includes opening statements by Senator William V. Roth, Jr., chair of the Senate Committee on Finance, and Senator Phil Gramm. Bruce Vladeck, administrator of the Health Care Financing Administration offered a statement as administration witness. Statements by public witnesses included those of: Robert Crittenden of the University of Washington School of Medicine; Don E. Detmer, on behalf of the Association of Academic Health Centers; Spencer Foreman, on behalf of the Greater New York Hospital Association of Academic Health; and Ralph W. Muller, on behalf of the Association of American Medical Colleges. Appended are prepared statements by the witnesses and communications regarding graduate medical education reform from the Alaska Family Practice Residency, American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Dental Schools, American College of Preventive Medicine, American Hospital Association, National Association of Children's Hospitals, National Association of Public Hospitals and Health Systems, and National League for Nursing. (MDM)

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S. HRG. 105-901

GRADUATE MEDICAL EDUCATION (GME)

ED 434 576

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MARCH 12, 1997

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Office of Educational Research and Improvement
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GRADUATE MEDICAL EDUCATION (GME)

WEDNESDAY, MARCH 12, 1997

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, D'Amato, Gramm, Jeffords, Moynihan, and Baucus.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order. I regret that Senator Moynihan will have to be a few minutes late because he is attending a markup in the Rules Committee and cannot be here for the beginning. But he asked me to proceed.

This is our fifth hearing on Medicare in the 105th Congress, and today we will examine Medicare support for graduate medical education. We will hear first from the Administration on the President's Proposed Reform, then turn to representatives of the nation's medical schools and teaching hospitals for their view on GME reform.

Medicare's funding of graduate medical education has been not only important to our seniors, but has provided a unique subsidy for the profession of medicine. At the inception of the Medicare program in 1965, Medicare allowed teaching hospitals to include the cost of training doctors and their Medicare charges.

In the early 1980's, with an introduction of a new payment system for hospitals services, Congress provided two separate payment formulas for GME. One formula provided for resident salaries; the other to offset other costs associated with training doctors.

I should note that both these generous formulas were written when Republicans held an earlier majority in this committee.

The extent of Medicare support for graduate medical education is quite substantial. In 1996, Medicaid paid $6.7 billion for GME, and we will spend, under current law, $49 billion from 1997 to 2002.

In practice, GME goes to teaching hospitals. Teaching hospitals offer highly valued services to Medicare beneficiaries and others. Teaching hospitals play a unique role in developing new innovations in medical care as a site for medical research, in caring for

the poor, and in helping to insure there is a well trained physician workforce.

In today's highly price sensitive medical marketplace, it is important that we understand how teaching hospitals are fairing; however, times change, and we must look carefully at all our Medicare expenditures. Moreover, we must recognize independent authorities have raised very important questions about whether Medicare GME subsidies work as intended, suggesting we give this issue careful review.

At this time, I will turn to Senator Gramm.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS

Senator GRAMM. Mr. Chairman, I want to thank you for holding this hearing.

Several weeks ago I met with Bruce and with the Secretary to talk about Medicare reform, being the new chairman of the Healthcare Subcommittee. I recognized that if we were going to have any chance of preserving the solvency of Medicare, especially the Part A Trust Fund, that we had to do it on a bipartisan basis.

One of the things I talked about during those meetings was the need to go beyond the five-year cost projections and look at longer term medicare costs, something I do not think we have done, either in this committee or in the Congress. And I specifically raised a concern about new Medicare benefits proposed in the President's budget.

I had gotten information from academic circles—which may have, in fact, been based on some unofficial HCFA numbers—that one add on in the budget, eliminating co-payment for outpatient care, when fully implemented, would cost more than $100 billion over a 10-year period.

I raised that concern at a previous hearing. I got no response from the Secretary on it, and I had asked that I be given, from HCFA, cost estimates on these policy changes for not just the 5 years, but for 10 and 20.

This morning, Mr. Chairman, I received, by voice mail, a message from the Deputy Director of HCFA for Legislative Affairs saying the administration has decided that only five year estimates will be provided. The administration will not provide any longer term estimates.

Let me assure you, you will, or I am going to hold every one of your nominees. No one will be confirmed by the senate for any appointment at Health and Human Services until I have those numbers.

We have to be honest with each other, and I cannot make decisions, as chairman of the subcommittee, if I am not given the facts. So I am going to get these numbers. I am going to keep after you until I get these numbers.

We have a right to have these numbers. I feel perfectly free to ask the Senate to vote to mandate the release of these numbers, because one of the things we have got to do is understand the basic facts involved.

Finally, Mr. Chairman, let me say again that I want to thank you for this hearing. I am very concerned that we have two major

expenditures from the Part A Trust Fund that do not belong in the Part A Trust Fund.

One of those expenditures is Graduate Medical Education, and the other expenditure is disproportionate share. And let me explain why they do not belong in this trust fund.

First of all, this is a trust fund that is not paid into by everybody. It is a trust fund that is funded by taxes on younger workers where only wages are taxed. Profits are not taxed; interest is not taxed. This is a working person's tax. It is also paid for by deductibles and by co-payments from people who participate in Medicare Part A.

The idea that we are taking money out of a trust fund, which is now in the red, which will be insolvent in 4 years, which has a 10-year projection by CBO of a $600 billion deficit, in order to fund indigent health care, and to fund graduate medical education, is clearly and profoundly wrong.

I favor Federal support for graduate medical education, but I think it ought to be an appropriated account. I think we ought to know what is happening to the money. I think we ought to hold hearings on what the money is being used for.

And finally, Mr. Chairman, let me say that I have heard some bad ideas in my life, but let me make it clear that the administration's idea of paying people not to train doctors is one of the stupidest proposals that I have ever heard of in my life.

If you want fewer doctors trained, grant fewer subsidies. But do not pay people not to do it. We are getting ready to turn this whole thing into a 1950's farm program. If the government really believes we are training too many medical residents, stop funding so many residents and the market will work.

It is interesting that there appears to be only one market on the planet where applied technology costs you money, health care in America. There is only one market on the planet where having more doctors drives up health care costs instead of drives them down, and that is the health care market in America.

And the reason that both those are either true or believed tc be true is because of how distorted this market has become because of government policy.

And, I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Gramm. Let me just urge that this information be made available. I do not think it helps the process for full disclosure if information is not to be made available to all interested parties. So I sympathize with the request of the distinguished Senator from Texas.

Dr. VLADECK. Mr. Chairman, if I may?

For the record, I believe it would be inaccurate to say that this is a decision that affects only 10-year Medicare projections.

In fact, the message that we provided Senator Gramm was a result of an OMB policy decision about budget projections the numbers across the board throughout the budget. And we will make sure that that generic discussion, because that is the level on which it has taken place, is appropriately adjoined by the folks who are appropriately participants in it. We will undertake to do that.

Senator GRAMM. Mr. Chairman? In essence, is what you are saying is that OMB has said they do not give this data out in any area beyond 5 years?

Dr. VLADECK. As I understand it, their positions were the 5 year numbers, and they have not singled out Medicare, in that regard, in any sense.

Senator GRAMM. Well, it seems to me, again, that this is just one manifestation of where we need the facts. And maybe I ought to broaden these holds on these appointments if it is an administration-wide policy. Thank you.

The CHAIRMAN. Thank you.

All right. Let us proceed with this hearing. Dr. Vladeck, of course, heads the Health Care Financing Administration, which manages Medicare. It is my understanding that you will discuss the present GME proposal.

Your full statement will be included in the record. Please summarize the significant points. Thank you.

STATEMENT OF HON. BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. VLADECK. Thank you. I very much appreciate the opportunity to be here today to describe the President's fiscal 1998 graduate medical education proposals and to make some brief comments about the recently approved demonstration project, which we believe has been inaccurately characterized as paying hospitals not to train physicians.

If I may take just a second, on a personal note, I am particularly pleased to be here because I have been personally involved in discussion of these issues for the last 20 years, including my membership years ago on the New York State Council in Graduate Medical Education, a number of years on the Perspective Payment Assessment Commission—where we probably spent more time on this issue than any others—and a number of other roles.

And after all these years of discussion and no action, it is gratifying to believe that this may finally be the year in which some of the reforms around which there has been very broad consensus may actually come to fruition. I think we all agree, as a matter of fact, that Medicare payments are currently central to the funding of graduate medical education.

The high-quality research and medical research, as well as clinical services, that occur in our academic medical centers are one of the nation's great assets, internationally recognized, and it is important that they continue to be supported. However, it is also clear that there is a national consensus that we have not only a surplus of specialists, but a significant physician distribution problem, with not enough primary care physicians in areas where they are needed.

Medicare is in a position to favorably influence the supply and distribution of physicians since it currently provides such powerful financial incentives to hospitals to increase the number of residents they train.

What I would like to do very briefly this morning is to just review how the incentives provided in the past for Medicare payment

policy have overpowered market incentives that might have affected the number of residents, and then tell you what the President has proposed to do about that.

Of course, historically, the Medicare paid for inpatient hospital services, including the training of interns and residents on a cost basis. But when Medicare began paying through the prospective payment system in 1983, we recognized the teaching hospitals serve a special population and that teaching itself means that care in teaching hospitals is intrinsically more expensive than other hospitals.

To recognize that, Medicare makes 2 types of adjustments to the payment rates for Medicare discharges provided in hospitals with training programs; an indirect medical education payment, or IME payment, and a direct medical education payment.

Under current law, the IME payment is based on the teaching hospital's ratio of interns and residents to beds, which clearly provides incentives for hospitals to train more interns and residents. RIME payments have increased from about $2.9 billion in fiscal 1990, to $5.1 billion in 1995, an increase of more than 75 percent.

Our current formula for determining the indirect medical education payments provides approximately a 7.7 percent increase in IME payments for each 10 percent increase in a hospital's ratio of interns and residents to beds. Studies by the Prospective Payment Commission by the GAO, by various academic experts, as well as our own, have shown that this formula compensates teaching hospitals in excess of the additional costs they incur in treating patients.

If enacted, the President's proposals would gradually bring the Medicare IME adjustment to 5.5 percent in 2002, much closer to the actual cost.

When PPS was created, it also excluded direct hospital costs from payment through PPS, including direct medical education costs, such as salaries and fringe benefits for interns and residents, the cost of supervisory teaching physicians, and miscellaneous overhead associated with operating training programs.

Since 1985, we pay teaching hospitals on a per resident basis for these direct costs. Our direct GME payments have increased from $1.3 billion in fiscal 1990, to approximately $2 billion in fiscal 1995, which is an increase of about 50 percent.

Organizations, from the Institute of Medicine to the Department's Council on Graduate Medical Education, to the Pew Charitable Trust, have all raised concerns that Medicare is providing incentives to train too many residents and too many specialists in inpatient hospital settings.

Experts have noted that medical practices training is changing, with an increased emphasis on primary care, and that the growth of managed care means a greater demand for physicians who have stronger skills in delivering primary care services.

Just 2 weeks ago, as I am sure you know, the American Medical Association, the American Association of Medical Colleges, and a group of other national medical organizations issued a consensus statement confirming their agreement that we have an oversupply of physicians and that the Federal Government must realign its GME funding policies to cease exacerbating that oversupply.

At the moment, we do provide some modest financial incentives to promote the training of primary care physicians. First, are direct GME payments are reduced past the time that training is needed to train one's initial specialty. Second, we do pay hospitals graduate medical expenses when a resident works in an ambulatory training site where the hospital continues to pay the resident's salary.

I should note, however, that under current law, we do not count the resident's time in calculating the indirect medical adjustment for that hospital. And since the indirect medical education adjustment is typically a much larger share of the hospital's total payments, we are concerned that Medicare's policy of not counting of the time residents spend in ambulatory settings for indirect medical education has been a significant disincentive for the expansion of such training.

Historically, when hospitals were paid charges or costs by all payers, the costs of medical education were shared by all payers. However, as managed care companies and other insurers negotiate with hospitals for lower payment rates, hospitals increasingly rely on Medicare to help finance medical education.

While we believe it is the responsibility of Government to support activities that are essential to the welfare of all its people, that does not preclude the need for other interested parties to do their part.

Senator Moynihan and others have introduced legislation to establish a medical education trust and medical education advisory committee, which would insure that private payers also contribute to the costs of medical education. There is, of course, a great deal of interest in these proposals, and we look forward to working on this issue with Senator Moynihan, with the Chairman and other members in this session of Congress.

Very quickly, the President's 1998 budget proposals include a number of provisions designed to alter the incentives and to more closely align them with incentives in the marketplace and consensus as to good policy in order to help achieve the following commonly agreed upon goals.

First, to stop the growth in the number of medical residency positions; second, to encourage more training in primary care; third, to encourage more training in non-hospital settings for all residents; and fourth, to provide more payment equity for teaching hospitals when they serve Medicare managed care enrollees.

Our legislative proposals are not designed specifically to redistribute primary care in residency slots, nor to force programs to downsize. We do not believe it is appropriate for Medicare to become involved in the micro-management of the details and operations of individual residency programs. Any effort to do so would be fraught with difficulties.

Given the dependence of many teaching hospitals on Medicare Graduate Medical Education funding, any major or overly prescriptive changes in payment policy could have serious ramifications. Nonetheless, we do support the following provisions.

First, we should cap the number of residents. Now, the total number of residents in this country, since 1990, is from about 107,000 to almost 130,000, a growth of 20 percent, during a period

when the U.S. population increased 6 percent, beginning at a time when everyone believed we had too many residency slots already.

To stop this rapid growth in the number of residents, we would limit Medicare's payment to the number of residency slots at each teaching hospital in the 1996 residency year. We would also cap Medicare's payments for indirect medical education, so that hospitals could not inflate intern and resident-to-bed ratios to gain additional payments by reducing their number of beds.

I should note that this proposal is supported by the American Medical Association.

Second, we propose to base direct and indirect medical education payments on a 3-year rolling average of the number of residents, rather than on the number of residents in a program in a given year, in order to reduce the financial impact of downsizing programs.

This is analogous to some of the concepts in our New York Graduate Medical Education demonstration, about which I will say a little bit more in just a moment.

Third, we believe we should make direct graduate medical education payments available in certain non-hospital settings. It is important that residents receive more training in these settings.

We propose to give Medicare the authority to pay certain non-hospital providers, specifically Federal qualified health centers, rural health clinics, and managed care organizations for the direct costs of medical education.

In order to qualify for these payments, those providers would have to participate in accredited teaching programs and bear the cost of the residency program. That is, to say, pay the resident's salary themselves.

Our proposal would also give the Secretary the authority to make graduate medical education payments through other non-hospital sites in the future, which we believe could be an important step towards improved medical care access in rural communities.

Fourth, we are proposing to allow hospitals to count residents serving in non-hospital settings, for the purposes of indirect medical education calculations, in order to encourage more training in such settings and to eliminate the current disincentives for hospitals to allow residents to rotate to them.

This proposal would not allow the resident-to-bed ratio to exceed the ratio that exists in the base year, but the hospital's payment would not decrease if a resident were transferred to a non-hospital setting, as long as the resident remained on the hospital's payroll.

Fifth, we are proposing a gradual decrease in the indirect medical education formula, from the current 7.7 percent, to 5.5 percent in fiscal year 2000 and the years thereafter. Again, all of the independent analyses of this calculation suggest that an adjustment in excess of 4 to 5 percent is not supported by the empirical evidence.

There has been clear bipartisan support for reducing the level of these payments, and similar proposals have appeared in all of the budget proposals from both sides of the aisle in the last several years.

Sixth, we want to make graduate medical education and indirect medical education payments for Medicare managed care enrollees directly to the hospitals. Now, we propose to extend our support of

those hospitals by directly providing them with payments of approximately $10.7 billion over 5 years for their treatment of Medicare managed care enrollees.

Under our proposal, Medicare would pay teaching hospitals directly, for both GME and IME, as well as disproportionate share payments, based on a number characteristic of Medicare managed care enrollees treated by the hospital.

Now, Mr. Chairman, we know you supported a similar initiative last year, and we look forward to working with you on this, as with all the other proposals.

We realize the significant impacts that changes to Medicare payment policy will have on residency training programs, and, given the importance of these issues, we have also entered into discussion with hospitals and State Government officials, from a number of States, to test other policy approaches to dealing with these issues, of which the one that has first come to fruition and has received the most attention is the demonstration in New York State.

New York's hospitals train a formidable 15 percent of the nation's residents and receive 20 percent of Medicare's annual spending on graduate medical education activities, a current level of about $1.4 billion a year.

Although many hospitals in New York State have reported that they have considered downsizing their teaching programs for a variety of reasons, there has, in fact, been little movement to date. Over the last 4 years, the number of residents trained in New York State actually increased by more than 11 percent.

In view of this, we responded positively to a proposal from the Greater New York Hospital Association, which we believe will serve a number of important national goals. It will significantly reduce the overall number of residents, it will increase the emphasis on primary care training and on training in ambulatory sites, and it will help teaching hospitals adjust to the demands of rapidly changing health care markets.

Participating hospitals and their medical leadership are responsible, within the broad design of the demonstration, for determining implementation strategies that fit the unique teaching missions and unique service needs of the community served by each institution.

This demonstration will help New York's teaching hospitals evolve into more focused and innovative organizations by providing transitional payments to assist hospitals re-engineer the ways they provide care, while reducing the number of their residents by 20 to 25 percent.

In the course of that, saving Medicare, over the 6 years of the demonstration project, anywhere from $300 to $650 million, depending upon how you make estimates about some of the secondary impacts of the reduction in training programs.

We have had conversations with folks both in the State of Utah and the State of Michigan about somewhat analogous kinds of programs, although in both Utah and Michigan they are talking about broader participation from other payers.

In New York State, the payers, other than Medicare, are already participating in pooled graduate medical education of funding under State law enacted last year.

In conclusion, Mr. Chairman, there is broad consensus among everyone who has looked seriously at this issue about the goals for reforming Medicare payment for graduate medical education. Everyone agrees that we need to let the market appropriately determine how many and what types of residents are trained and that Medicare should not be in the business of micro-managing the nation's graduate medical education programs.

On the other hand, Medicare has played an integral role in supporting medical education and must continue to do so. There is clearly a need for reform, and we are heartened by the level of consensus that appears to exist around various proposals for such reforms.

We very much look forward to working with you and the other members of the committee so that this can be the year that we finally do get off the dime and begin this enormously important process of re-shaping the way Medicare pays for graduate medical education, and thus, the way graduate medical education evolves in this country.

Thank you again for the opportunity to be here today. And, of course, I am happy to respond to any questions.

[The prepared statement of Dr. Vladeck appears in the appendix.]

The CHAIRMAN. Dr. Vladeck, why should Medicare pay transitional payments to help teaching hospitals downsize? Why should not the hospitals simply make the number of residents a business decision?

You have talked about the New York demonstration program, but I understand the other teaching hospitals have approached HCFA for transitional payments to ease the downsizing of their residency programs. Could you tell me where those hospitals are?

And second, do you think it would be proper exercise of HCFA's demonstration authority to provide transitional payments to other hospitals? Or should any further expansion of this demonstration be done by legislation?

Dr. VLADECK. Mr. Chairman, we have had inquiry from dozens of hospitals and hospital associations about demonstrations analogous to that in New York, but we have received no other proposals for such projects. We have been in conversations, as I said, with folks from the State of Utah and folks from the State of Michigan about somewhat differently shaped proposals.

We have told folks in the academic medical community throughout the country that we would clearly be interested in different proposals that would involve demonstrations that would change and refocus graduate medical education; that if we received a proposal identical to that of New York's, we would have to think seriously and consult with the Congress about what the boundaries of our demonstration authority ought to be.

But, as of the moment, we have not received any such requests. And given where we are in the legislative process, I think it is likely that the Congress will move faster than we ordinarily would, in any event, to make such changes.

The CHAIRMAN. I have two questions about Medicare Graduate Medical Educational payments for international medical graduates.

How many medical residents does Medicare help support who graduated from a medical school outside of the United States?

Dr. VLADECK. Mr. Chairman, I think about 20 percent of all the residents in the country, at the moment, are graduates of foreign medical schools. Let me correct that. About 23 percent. And that number would come to 6,000 to 7,000.

The CHAIRMAN. But what would be the annual cost of that?

Dr. VLADECK. Well, we do not know precisely, but a good rule of thumb with that would be roughly 23 percent of our total graduate medical education subsidies, and therefore, it would be about a $1.5 billion, I would guess. Or $1¾ billion a year. Somewhere in that range.

The CHAIRMAN. A sizeable amount.

Dr. VLADECK. Yes, sir.

The CHAIRMAN. The administration has proposed putting a cap on the number of residency positions that Medicare will fund; however, at a hearing last week, the Chairman of the American College of Surgeons proposed that the total number of resident positions in teaching hospitals should be reduced to about 110 percent of the number of U.S. medical school graduates. That is roughly 6,000 fewer students currently.

What do you think of this proposal as the basis for the number of residents Medicare should support through GME payments?

Dr. VLADECK. Mr. Chairman, I think there is general agreement that a number in the range of 110 percent or 120 percent of American graduates is the right range. But I do not know how, from the viewpoint of Federal policy or Medicare policy, you get from here to there. That is, to say not all residency programs are of the same quality; not all of them are in specialties that are oversupplied; not all of them are in communities in the United States that are oversupplied with physicians.

Once you start putting a cap or a ceiling below your current levels, you begin to get into a series of allocated decisions and allocational choices that I do not think is desirable and perhaps not even appropriate for Medicare to make.

The CHAIRMAN. One final question. My time is up. I would like to ask why the administration does not seek greater reduction in indirect medical education costs.

As I understand it, the indirect medical education adjustment, according to the administration, would be ratcheted down to 5.5 percent per a 0.10 rise in teaching intensity by 2002 from the current 7.7 percent. But ProPAC says that an adjustment of 4.1 percent more closely corresponds to the actual relationship between teaching intensity and cost.

So I have 2 questions. First, does the administration agree with ProPAC's estimate, that 4.1 is correct? And if the administration does agree, why not reduce the IME adjustment that much?

Dr. VLADECK. Well, if I could perhaps take your questions in reverse order, Mr. Chairman. ProPAC has recommended that—consistent with their empirical analysis—we reduce the IME in fiscal year 1998 from 7.7 to 7 percent. They have always supported undertaking any reduction in indirect medical adjustments in a phase step-wise process.

We may disagree about the timing or magnitude of those steps, but we very strongly agree with ProPAC that these reductions should not all be taken at once.

On the precise number, their estimate, again, has been in the range of 4 percent. Some other estimates that we have looked at are closer to 5 percent. Frankly, at that level, you are getting into splitting hairs.

I think the empirically correct number is somewhere between 4 and 5 percent, and we ought to move in that direction. But we ought to do so in a way that recognizes the potentially disruptive impact on very important institutions.

The CHAIRMAN. Well, what you are saying is it ought to be phased in, but you do not make any proposal to phase in below the 5.5.

Dr. VLADECK. Well, as Senator Gramm has quite correctly pointed out, our proposals only extend through the year 2002.

The CHAIRMAN. That is 5 years.

Dr. VLADECK. Yes, sir.

The CHAIRMAN. That is quite a slow phase-in. One final question. One of the rationales for indirect medical education payments is that these payments not only help doctors in training, they also help compensate teaching hospitals for sicker patients. Yet Medicare provides an adjustment through PPS for outlier payments to hospitals for treating sicker patients.

In any case, a general subsidy seems an odd way to accomplish this goal. Does the administration believe we should pay IME teaching funds to hospitals for treatment of sicker patients? Or for both reasons?

Dr. VLADECK. Well, again, if I can go back to your earlier question, Mr. Chairman, lots of people have—for years—been running these analyses, which show that controlling for the same types of patients costs a teaching hospital roughly 4 percent more, or 5 percent more, per 10 percent increase in the numbers of interns and residents to care for any given patient.

The proportion of that 4 or 5 percent that is attributable to teaching processes themselves, or to clinical research that is not separately funded, or to other aspects of teaching institutions, I do not think anyone has satisfactorily disentangled.

But we have continued to maintain the position that it is important for the nation—for a number of reasons—to have teaching hospitals, and therefore, the Medicare hospital payment program needs to recognize that, all other things being equal, it costs those institutions 4 or 5 percent more to take care of patients, depending on the number of residents they have, than it costs a non-teaching hospital.

The CHAIRMAN. My time is up. Senator Gramm.

Senator GRAMM. Thank you, Mr. Chairman. I want to go one step deeper in the logic of graduate medical education funding through Part A of Medicare. Part A of Medicare is funded by 2 sources. One, a payroll tax on younger workers. They pay 2.9 percent of their payroll.

Of all major classifications of taxpayers, they are the poorest. No interest, no rent, no dividend, no profit is taxed to pay for Part A Medicare. Thirty percent of all income is, therefore, directly exempt

from any cost in funding Part A Medicare because Part A Medicare was originally conceived, though never implemented, as a quasi trust fund to fund.

Now, the other part of Part A is funded by co-payments and deductibles on our senior citizens. Given that funding mechanism, and given the fact that the trust fund is in the red for the first time in its history, given the fact that it will be insolvent at the end of 3 years, given the fact that CBO is projecting a $600 billion cumulative deficit in Medicare Part A in 10 years, how can it make sense that we fund graduate medical education out of a trust fund which is funded by taxing the lowest income wage earners and senior citizens.

And you could make the same argument for disproportionate share payments. Should we not take this out of Part A and put it into general revenue where it is funded by the general taxpayer, because the general public is the beneficiary?

Dr. VLADECK. Well, Mr. Gramm, we are prepared to talk about—and are very interested in—proposals that would create some sort of more broadly financed trust fund to finance graduate medical education and have no objections to continuing to explore that. And to the extent it removes outlays from the Part A Trust Fund, that would be fine with me as well.

But let me, if I may, just suggest that the rationale for paying for some of these expenses from the Part A Trust Fund is a little bit stronger than might be immediately apparent, and the reason is as follows: When Medicare provides hospital benefits to its beneficiaries, because, in part, of its size in the market as the purchaser of 30 percent or more of hospital services in the United States, we cannot—and I think, as a matter of public policy, it might not be appropriate for us to—buy on the margin. Or to buy selectively only from those institutions from which we could get the best deal if we were a 2 percent or a 5 percent or 8 percent market share.

We have to recognize that there is a national interest, and an interest in every community, in the existence of some kind of hospital system which has a number of characteristics, including probably the maintenance of some intrinsically uneconomic rural institutions and the maintenance of an academic enterprise or so forth.

And we think it is appropriate that Medicare, whatever the financing source, pay its prorata share for the maintenance of a national and a community based hospital system.

And just as, therefore, we justify making adjustments in our payments to support the availability of hospital services in rural communities, even when Medicare could buy those services cheaper in the next big town, so we think we have an obligation to pay our proportionate share for the maintenance of this very important academic medical institution.

But in terms of the A/B argument, I do not have any philosophical disagreement with you, sir.

Senator GRAMM. I guess the point I am making is we have to pay for graduate medical education. Everybody knows it, and I am willing to pay for it.

The question is, it seems to me, that while you can rationalize a Medicare overriding interest in physician graduate medical education, the reality is this was initially such a rich system, that it

seemed to make sense to reach in and use part of it to fund graduate medical education when we were expanding benefits, when we were benefiting from the massive number of baby boomers coming into the labor market, which started basically the day Medicare went into effect.

The point is everything has changed, and therefore, going back and redoing this process, it seems to me, makes sense. Let me make two other points.

I also think there is an argument that we would have better oversight of what we are paying for if we appropriated the money for graduate medical education, rather than having it funded in a hidden manner where there is not a great deal of accountability to anybody, other than someone who actually might be running the system who takes this on as a cause. And it seems to me that is a problem.

Finally, I want to urge you to talk to OMB and sort of have a prayer meeting with them about releasing numbers, especially in these big ticket items like Medicare. There is no reason that we should get into impasse this early in the process when the dispute is not about policy. The dispute is simply about trying to understand what it is that you are proposing and what it costs.

It seems to me that there are many things that we have an opportunity to have legitimate disputes about, but our access to information in trying to determine how much a program you have proposed costs is not one of those areas that we ought to be debating about.

And I hope that you will meet with them and urge them—because I know you can produce the data—to allow that to be shared with us so that we can look at Medicare, not just to the 5 years, which obviously were mandated in the budget, but for 20 years, which is a more reasonable planning horizon when you are talking about this kind of program.

Dr. VLADECK. Senator, I promise you I will convey that message. Probably not as eloquently as you have made it, but I will get the point across.

Senator GRAMM. I appreciate that.

Dr. VLADECK. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Vladeck, my compliments to you on proposing that GME be paid directly to hospitals, not to HMOs, for example, and I am very interested in your demonstration project in New York.

I would like to change the focus here a little bit though, from Manhattan, New York to Manhattan, MT. We, as you know, in Montana have no teaching hospitals. We have a lot of folks there, many of them not wealthy.

Seventy percent of the seniors in my State have incomes of $15,000 or less. That includes Social Security. And we have a hard time attracting doctors to rural areas of our State.

What provisions here are going to help us in rural parts of America? I am not talking about eastern rural. I am talking about western rural where, as you know, distance is much greater.

I am a little concerned. For example, you say you want to cap residency payments on 1996 levels. We are trying to get a family

residency practice program going in Billings, MT. We are just getting started.

As you might guess, it is a little difficult, based upon the statistic that most practitioners eventually practice in areas where they either grew up or where they went to medical school or had their residency program. I think about 60 percent of American doctors practice where they either grew up or where they had their residency program.

So what can you do for us in rural America?

Dr. VLADECK. Well, I think there are two particular provisions in the President's proposals that will be helpful and contribute to the design of the kinds of programs that we still need to develop or expand in rural communities.

The first is the provision that would pay other than hospitals' direct costs of medical education, particularly rural health clinics and Federal qualified health centers that would become eligible for direct Medicare medical education programs for the first time under the President's proposal.

Given where much of the training occurs in many family practices or other primary care residencies, we think that would be a considerable help.

Senator BAUCUS. What about the residency program in our State? I understand why—no offense—New York might be capped. But I cannot understand why struggling areas, like Montana, would be capped.

Dr. VLADECK. Well, I think part of the issue there—and it is not adequately addressed in our proposal, Senator. It is now constructed, but we need to talk about it—is that many training programs in rural communities are, in fact, affiliated with educational institutions or with teaching hospitals in metropolitan areas.

The papers I am shuffling through, I am trying to find my map of all the WAMI associated training sites in the northwest, which has been a major contributor.

Senator BAUCUS. WAMI helps.

Dr. VLADECK. Well, in part, the issue there has been associated with the difficulty that the university has had in bearing the cost of some of the training activities that take place in Montana or outside the metropolitan areas because a large part of those are nonhospital based and there has been this disincentive in the Medicare program, up to this time, to move those residents out of the hospitals.

I do not think this is, again, the total solution, but we do believe there is a substantially greater incentive for hospitals to move those residencies into those kinds of training programs, if you agree to count the full-time salaries of those residents in the hospital's indirect medical education calculations.

I also think we need to do something, however, and I think the pacific northwest is one example. I think there are other examples on the east coast and elsewhere of looking at ways—as is increasingly done—to essentially pull physicians across institutions or across training sites.

One of the things that is taking place in New York State that is a part of our demonstration is the encouragement of multi-insti-

tutional consortia, which involve one or more medical schools and a range of hospitals and primary care centers.

Senator BAUCUS. I appreciate that. My time is expiring here. I would like you to take another look, frankly, at your proposal to cap at 1996 levels. There has got to be a way to work this out for the growing areas like the one I mentioned.

Dr. VLADECK. I think there are ways to.

Senator BAUCUS. Second, there is, I think, a quite strong mal-distribution of Medicare payments to managed care organizations. We, in Montana, for example, receive less than half of what other managed care companies will get in other parts of the country. Let us say Florida. Much less than half. I think it one-third that they receive.

Very few people in our State belong to managed care. We are trying to struggle to setup managed care organizations, but because the payments are so low, and the cost of living, I might add, is very high, Montana faces very high costs.

For example, an airline ticket from Billings, Montana to Denver, round trip, coach is 900 bucks. It is ridiculous. And add to that the mal-distribution of Medicare payments, basically to States like Montana, compared with the more popular States, like Florida, and I ask you to go back and figure out a way to address that problem.

What we are doing, basically, with lots of Federal programs is helping urban areas and taking out of the pockets of rural areas, and it is quite a problem.

Dr. VLADECK. Thanks, Senator. We have, in the President's budget, in our HMO payments, a major redistribution from urban to rural areas, including a $350 per month for the Medicare capitation payments to rural counties, which we estimate, in a typical rural county, will increase the Medicare HMOs payments, over the 5 years of the budget area, by between 35 and 50 percent.

Senator BAUCUS. My analysis of that though is it is far from adequate. Far from adequate. It is just a faint in that direction. It is not really that substantive. Again, my time has expired, but we are going to be working on this one.

Dr. VLADECK. I would be happy to talk further with you on that.

Senator BAUCUS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

Senator D'Amato.

Senator D'AMATO. Thank you, Mr. Chairman.

Mr. Chairman, let me commend you for calling this hearing. I think it is important.

I think it is appropriate because there has been so much wind in the night; consternation over something that is probably one of the most enlightened moves undertaken by HCFA—long overdue—in an attempt to deal with the burgeoning costs and bring about some cost containment in a rational manner. We are talking about hospitals; we are talking about patients, we are talking about communities that need to be served.

I cannot, for the life of me, think of why it is that everybody would be screaming and shouting before they made an attempt to get the facts. They are entitled to that.

New York is going to get paid millions and millions more. What is the justification? Well, if people would take the time to look and

to see, the fact of the matter is, if they continue business as usual, there will be no savings and wind up with the people of the United States, this Government, paying $300 million more to do business as usual. Now, you have got to leave people with an alternative.

Do you want to do business as usual? Fine. The Government will pay to the New York Hospitals graduate medical education; $300 million more. No one is suggesting that they reduce the amount of payment because that is basically about $100,000 for a graduate medical student.

I have not heard anybody say reduce it. If you want to reduce, well, try. See what happens. You will see the hospitals in California and Texas and other areas screaming and yelling.

And so now we come forth with a demonstration plan, which shows some enlightenment that begins to find a glide path to reducing the number of students, of doctors, by as much as 25 percent. Now that is a heck of a reduction, 25 percent.

Now, if you did business as usual, you would not reduce the number, and you would not save as much as $300 million at the end of the demonstration plan. That seems, to me, to be good sense; a plan which the hospitals can implement; a plan which will not create consternation in the communities that are affected, that are served. Some of the poorest of the poor.

And one that is certainly a State that produces about 15 percent of all of the doctors nationwide, and a much higher percentage from those who come out of foreign schools. And, by the way, many of those students who go to these foreign schools, are our own U.S. citizens. Is that right, Doctor?

Dr. VLADECK. About half I believe, sir.

Senator D'AMATO. So this is not a bunch of so-called foreigners who are coming in. Half of them are U.S. citizens; young people who, for the most part, have got pretty good grades, but because of the competition, could not get into medical school. Grade A students.

Now, I think, as some have characterized, Jim Talone, who was President of the United Hospital Fund, a research and philanthropic group—called this a win, win. It is a win, win. We are going to actually reduce the number of dollars going to the New York hospitals. As a result of this, we are giving them a manner and a segue to reduce this so that they will not destroy medical teaching, medical care and, it can be—probably the harbinger in the future—for other institutions nationwide.

Why should not the great institutions, teaching institutions, that have the same needs and the same concerns be able to opt in if this plan begins to demonstrate that it pays; that it pays not only in insuring good medical care and training, but also in reducing costs to the Federal Government.

Now, if you said at the end of this it is going to wind up costing the taxpayers more, fine. Let me ask you one question. Is there any incentive at the present time, an incentive to reduce the number of residents under the current program that we have?

Dr. VLADECK. No, sir.

Senator D'AMATO. The plan that we have put forth and that you have approved, HCFA? Does it provide an inducement to reduce the numbers?

Dr. VLADECK. Well, it provides a transitional payment for those institutions that reduce it. And how much of an inducement, is up to the institution.

Senator D'AMATO. Last, but not least—and I think that is another important program—you should let the institution decide how to reduce and where to reduce, as opposed to some government cap that comes in. I could not think of anything more destructive than caps, to be quite candid with you.

You have got to be very careful when you get into this allocation of how many doctors, how many specialists, how many this, how many that. That is very dangerous. And the last group that should be doing that is government. Just think about that as a philosophy.

Let us provide incentives and ways. Let the market place still continue to work as best it can.

Last, but not least, in fullness of time, if we continued business as usual, in terms of the graduate medical program, as opposed to the demonstration program, I have been told that we will save as much as $300 million under the demonstration program. Is that correct? We, being the Federal Government.

Dr. VLADECK. We believe $300 million is a conservative estimate of the savings, Senator.

Senator D'AMATO. So, Mr. Chairman, if we take the time out to analyze—in the totality, not as opposed to those guys are getting something that we are not getting—we find out that actually it is going to save $300 million and reduce the number of doctors, it seems to me that is an enlightened approach.

And indeed, if there are other States that have that kind of program, I think we should support it. It makes sense, and I would be supportive. I would imagine HCFA would look favorable where the odds are stacked up that it is not going to cost more, but indeed, will cost less.

I thank the Chairman. And I want to congratulate HCFA for undertaking this initiative.

The CHAIRMAN. I just want to ask two questions as follow up. One question that has been raised is why not pay the subsidies directly to the resident, rather than to the hospital, to eliminate the incentives?

Dr. VLADECK. Well, there is a couple of reasons there, Mr. Chairman. The first is that the direct compensation of the residents is only a very small fraction. Or it is only a fraction of the total cost of running a graduate medical education program.

If we estimate that the total Medicare reimbursement for each additional resident for hospital, on average, is $95,000 to $100,000 a year. Of that, at the most, $35,000 to $40,000 of that is the direct compensation of the resident. The rest are either other direct costs borne by the teaching program or the indirect adjustments.

So, if you were to do that, you would be taking two-thirds of the dollars out of the system.

If I may correct the record just very quickly in one of my responses to Senator D'Amato. About half of the foreign medical graduates in the United States are either American citizens or legal permanent residents. Some of those are folks who are permanent legal residents, but are not citizens in that half of foreign graduates.

The CHAIRMAN. Is that at the completion of their residency? As I understand it, of the foreign students, something like 8 percent are those who have studied abroad. Are 8 percent. But many of them subsequently become citizens or permanent residents. Is that correct?

Dr. VLADECK. I think a very high fraction of all foreign medical graduates who train in American teaching hospitals, when they are not citizens, do, in fact, eventually become citizens or permanent legal residents.

The CHAIRMAN. What percentages are citizens when they begin the residency?

Dr. VLADECK. Well, again, I think about 20 percent are citizens at the time they begin residency. But I think about another 20 percent or so are permanent legal residents who, some portion of them—we do not have good numbers—were permanent legal residents before they went to medical school.

Given the growth in immigration in many of our metropolitan areas, and the movement back and forth of legal immigrant communities, there are a fair number of folks who are legal residents of this country who may return to a country of origin for medical education and come back here for training.

My staff, which is on top of these things, says of all the foreign medical graduates, one-fourth of them are American citizens at the time they start residency and another one-fourth of them are legal residents. But some of them have only become legal residents for purposes of residency. Some of them are legal residents before they began their medical education.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Doctor Vladeck, I appreciated meeting with you earlier this week. I have a few follow-up questions about your demonstration project.

First of all, will there be any specificity with respect to specialty restrictions?

Dr. VLADECK. Yes. Part of the plan that each institution has provided as a condition for participation in the program, and the conformance with which will be monitored throughout the life of the demonstration, is that there be no increase in specialty training and that as they shrink the total number of positions, the proportion of specialty training not increase.

Some of them will take all of the reductions from specialty slots, but none of them will increase either the number of specialty training positions, nor the proportion of specialty positions in their total residency program.

Senator JEFFORDS. Are you providing any guidelines with respect to the goals of the hospitals? Or are the hospitals setting their own goals?

Dr. VLADECK. Well, the broad goals were agreed on between us and the hospitals. The goal of a 25-percent reduction in the total of house staff, or a 20-percent reduction when combined with primary care enhancements or consortium development where set by us as a condition of the demonstration.

We have also set some additional conditions having to do with the protection of safety net providers, with the ratio of primary care to specialty training and so forth. But the specific details of

the timing phasing nature of the actual reductions themselves will be decided upon by each institution.

Senator JEFFORDS. Will you be monitoring the progress of this program? Or is that being done by New York? Or has it been done?

Dr. VLADECK. We are going to monitor it ourselves very closely, but in addition to which we are also going—as is our custom with demonstration projects of this character—to contract with an independent entity to provide a third party evaluation of this entire program.

Senator JEFFORDS. Now, as you know, there is a tendency to reduce substantially the number of beds in hospitals and to do more work outside of hospitals. How does that affect residencies, and, does that change this kind and quality of health care?

Dr. VLADECK. Well, again, in the New York program, some hospitals have chosen to take a 25-percent reduction in the total number of positions. Some have chosen to take a 20-percent reduction, in conjunction with a significantly expanded series of outpatient based primary care training activities.

Senator JEFFORDS. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, as you knew, I was asked to be at the White House for the announcement of the President's Highway and Surface Transportation Act, and it took longer than it should.

I am sorry to have missed your testimony, Dr. Vladeck. But I did read it, and I appreciate it, and I will not trouble you further.

Dr. VLADECK. Thank you.

The CHAIRMAN. He is too easy on you. We may have additional written questions, Dr. Vladeck.

Dr. VLADECK. We are always happy to try to respond to the committee, Mr. Chairman.

The CHAIRMAN. Thank you very much for being here today.

Dr. VLADECK. Thank you.

The CHAIRMAN. It is now my pleasure to call forward a panel consisting of Robert Crittenden, M.D., Director, Office of Education Policy of the University of Washington School of Medicine, Seattle, WA, and Dr. Detmer, Senior Vice President, University of Virginia, Charlottesville, VA. He is here on behalf of the Association of Academic Health Centers.

Dr. Spencer Foreman, President of the Montefiore Medical Center, Bronx, NY. He is here on behalf of the Greater New York Hospital Association. Ralph Muller, who is the President of the University of Chicago Hospital, Chicago, IL, here on behalf of the Association of American Medical Colleges.

Your full statements, in each case, will be included in the record, and I ask that you would summarize them in five minutes. And, Dr. Crittenden, we are be pleased to start with you.

STATEMENT OF ROBERT CRITTENDEN, M.D., M.P.H., DIRECTOR, OFFICE OF EDUCATION POLICY, UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE, SEATTLE, WA

Dr. CRITTENDEN. Thank you very much. I am Bob Crittenden, and I am with the University of Washington. I am the Director of

Education Policy, and I work very closely with the WAMI Program in the northwest.

We are about 25 percent of the landmass of the United States, involving five States and involved in education from the undergraduate through, actually, community development and CME, including residency programs, which is the focus of the discussion today.

I see myself as a transition between the discussion going on here today, which is talking about a fairly abstract dollar percentages, and what really goes on at the community level, and what is happening actually in Montana, Anchorage, Alaska, Eastern Washington, and places like that.

I would like to make just three points today. One is that there is a need, despite having too many doctors in our country, for distribution; for physicians in the right place at the right time and the right kind.

The second thing is that it does take residency programs that are focused on those issues to resolve those issues.

The third thing is that Medicare funding—a lot of this GME funding we are talking about today—makes a huge difference to these rural based residencies, and community based residencies.

And the last thing I want to talk about, briefly, is the GME carve-out issue, and I will comment a little bit on the administration's proposal. The GME carve-out being that managed care, while it is moving into these even very rural areas, will have a huge impact, and a negative impact, unless the Congress decides to do something about it.

From our university's perspective—a little background—we have our feet in both camps. Clearly we are one of the leading research institutions in the country. I think we get the second highest number of research grants from NIH.

At the same time, we have a very distinct and clear role in training people in distribution and to train and work in rural communities. With that, we have programs. And I think there is a map in your handout, which at least looks at and describes a very regional program. Our education is very diffuse, and it involves providers in all those different places; all the different States, including Alaska, Montana, Idaho, and now, our newest is Wyoming.

The issues with the WAMI Program, which is our regional program, is that we really have to meet the physician needs in those communities. We are held responsible and accountable by the legislatures in those States on a yearly basis, and I think we are fairly responsive to that.

I will use Alaska and Montana as examples. We know the people who are trained in those communities, stay in the communities. We know that people who actually live in those communities for a period of time—when they first come out of residency—will stay there. If they go to urban areas, they will not ever go to rural areas.

And we know that the training that we have in this diffuse program is excellent training. We have compared graduates in every measurable way we can, and they compare favorably to our urban trained folks.

Today I want to focus on finance. There is a pie chart, which is in your handout, which is the revenue that the Boise residency has given us—which is the Family Practice Residency of Idaho—and that shows that about 25 percent to one-third of the costs of these residencies comes from GME. The part that is called hospital is actually the pass-through from the GME money. So these programs depend on this money.

A Good examples are the two we have recently started, the Anchorage or the Alaska Residency, and the Montana Residency in Billings. In fact, it is very clearly a situation where those particular hospitals looked at what money they could derive from Medicare and used that as their contribution.

Most of the rural hospitals do not have a lot of extra funds, and this is a way from them to actually start stepping up to the table and supporting these programs. So it is important.

I want to talk about the recommendations. We support a lot of the recommendations from the administration. The GME carve-out, we are going to be moving into managed care more in all these communities. One needs to be segregated and made available for residency training.

The issue that was brought up of counting the time away from hospitals in community based settings is essential for the kind of training we do.

There is one thing that was mentioned earlier by Senator Baucus having to do with the cap. We believe the cap should not apply to rural areas. The Montana residency will be stopped in its tracks; the Anchorage residency will not even get off the ground if that happens. That would be a travesty to actually addressing the distribution issues.

And last, let me make two quick points. One is I think a start-up fund for these residencies would be a worthwhile thing to do. And one thing is we do agree very strongly with the AAMC, AAHC and other groups who have come together and said that the Federal funds ought to be prioritized to urban and rural under-served populations, and we think that should apply also through our Medicare funds. Thanks.

The CHAIRMAN. Thank you, Dr. Crittenden.

[The prepared statement of Dr. Crittenden appears in the appendix.]

The CHAIRMAN. Dr. Detmer.

STATEMENT OF DON E. DETMER, M.D., SENIOR VICE PRESIDENT, UNIVERSITY OF VIRGINIA, CHARLOTTESVILLE, VA, ON BEHALF OF THE ASSOCIATION OF ACADEMIC HEALTH CENTERS

Dr. DETMER. Thank you. Good morning, Mr. Chairman, members of the committee. I thank you for this opportunity to present the views, and I am really here wearing two hats today.

The first is co-chairman with Neal Vanselow of the 1996 Institute of Medicine Study on the Physicians Work Force, and second, as a representative of the Association for Academic Health Centers.

This was one of the six organizations that recently presented the consensus statement that was mentioned by Dr. Vladeck. If there is time, I may make a few about the AAHC positions as well.

The Institute of Medicine Committee included a number of different people from different perspectives and disciplines. Among those on the group were Dr. Foreman, to my left.

Most studies on the adequacy of physician work force the past 15 years have concluded that the U.S. already has, or will soon have, an oversupply of physicians. Graduate medical education plays a significant role in U.S. physician supply and care delivery, research and medical education, all desirable national goods and public goods.

Since 1988–89, the numbers have steadily increased at about 4 percent per year. The number of U.S. medical graduates in graduate medical education training has remained stable since the early 1980's. But between 1988 and 1993, the number of IMGs and residencies, or fellowship training, increased by 80 percent.

The number in first year positions grew by more than 3,200 between 1988 and 1993, whereas the number of U.S. medical graduates actually declined by nearly 230 individuals during that period. The IMG trainees are now equivalent to the total output of over 25 mid-sized U.S. schools annually.

In short, the issue of the long-term match between the supply of physicians in this country and the expected requirements for physicians services cannot be addressed without consideration of the role of GME and the role of IMGs within GME.

There is a temptation to argue that a significant physician output might have a beneficial impact on cost, access and quality. This should be resisted because the assertion does not stand up to scrutiny on the basis of the research data available.

In our Nation's record in addressing these issues, even with a dramatically increased supply of physicians, it has been far from adequate. For example, an abundance of physicians is not so far and, by itself, solved some of these problems of geographic distribution that we have already heard about this morning. Targeted programs can achieve these ends.

Further, one cannot demonstrate that the surplus will improve the quality of patient care. In some scenarios, it may dilute quality. And a surplus will contribute to aggregate health care costs, at least as long as the nation has a significant fee-for-service sector.

In short, simply having more physicians beyond its clear adequacy or abundance has not meant having the right care, at the right place, and at the right cost. Having far more physicians then is needed to meet the nation's requirement is a waste of Federal resources currently spent on graduate education, and some people argue the investment on the parts of prospective medical students is a waste of human resource.

The committee believes, however, that a better balance is to be achieved to avoid a serious oversupply. These are long training pipelines, and unless we deal with them, we will have trouble later trying to pull it under control.

Clearly, if the nation had to choose today between too few physicians and too many, it would prefer in excess to a dearth. There appears little to be gained from a huge imbalance.

So the IOM committee recommended that no new schools should be funded and no public funds available to open new schools, if allopathic or osteopathic medicine; that Federal Government

should reform policies related to the funding of graduate medical education and bring the support nearer to the total number of first year residencies from the current number of graduates of U.S. medical schools.

The Federal Government, the State Governments, take immediate steps to develop a mechanism for replacement funding for IMG dependent hospitals that provide substantial amounts of care for the poor and disadvantaged, that the Department of Health and Human Services and professional associations make information on physician supply and requirements available to prospective students so they can make better decisions about their careers; policy makers, educators, professional associations and the public.

Finally, the Department of Health and Human Services needs to provide resources for research on this. This study, like many others, is looking at a changing target. And as we change policies, we need to continue to look at this over time.

As you may be aware, the Institute of Medicine is currently conducting a study that will recommend a methodology for teaching hospitals and graduate medical education, including allocating funds form a graduate medical education trust fund.

A formal request from representatives Archer, Thomas and Johnson was made to President Shine in July with a hope that advice would be available early this year. The trust fund study began in August, is currently on their review process, and the IOM seeks to have the report completed this spring. I think that could be quite useful to you.

As I mentioned last month, six medical associations released a consensus statement on physician workforce. It was the first time in history actually that 6 of the nation's leading medical associations have advocated a unified approach for addressing physician workforce issues.

The Institute of Medicine was drawn upon for that activity, but was not actively involved itself.

I think, in the interest of the time, I basically will say that they essentially argued the key points; to limit entry level positions more closely to the number of graduates of accredited U.S. schools, and that we should continue to provide GME opportunities for foreign born physicians who have graduated from non-U.S. medical schools, but under the J–1 Exchange Visitor Program.

I think, in summary, to cut through some of the other recommendations, that I really am pleased that the Federal Government is looking at this. I commend this very much. I think the New York experiment represents a start at reform, and its evaluation will prove quite useful.

While a healthy workforce policy is complex, it is in the public interest to have well-trained, caring health professionals, and supporting the high cost of training is in the public interest.

I appreciate the opportunity to present my views, and I would be happy to respond. Thank you.

The CHAIRMAN. Thank you, Dr. Detmer.

[The prepared statement of Dr. Detmer appears in the appendix.]

The CHAIRMAN. Dr. Foreman.

STATEMENT OF SPENCER FOREMAN, M.D., MONTEFIORE MEDICAL CENTER, BRONX, NY, ON BEHALF OF THE GREATER NEW YORK HOSPITAL ASSOCIATION OF ACADEMIC HEALTH

Dr. FOREMAN. Good morning, Mr. Chairman and members of the subcommittee. As a New Yorker, I would first like to greet Senators Moynihan and D'Amato and to thank them for their unfailing and continuing leadership in general and their support in the area of graduate medical education.

I also wanted to align myself with Senator D'Amato's comments earlier because they were very helpful, and we think right on target.

Though my written testimony offered to the committee lays out a broader perspective, I would like to focus my oral comments this morning on the New York Medicare Graduate Medical Education Demonstration Project, which, as everyone in this room knows, has generated a considerable amount of interest.

Here are the facts as we see them: First, 42 public and voluntary teaching hospitals and academic medical centers, which collectively train about two-thirds of New York State's 15,000 resident physicians, will participate in this demonstration project, which will reduce the number of residents in those institutions by about 25 percent.

Second, the Medicare GME payments for the residency positions that are eliminated will be phased out, but the phaseout will be more gradual than the reduction of residents.

Third, at the end of the demonstration project, all of the reimbursement will have been eliminated, and the Medicare program will have a permanent, fixed savings thereafter.

Specifically, over the next 6 years, the positions eliminated will generate Medicare savings of about $700 million. The hospitals will retain $400 million, and the Medicare program $300 million. At the end of the experiment, Medicare will have an ongoing, permanent annual savings of about $200 million a year.

Our association proposed the idea for the demonstration in response to a growing concern among policy makers in the profession—as you have heard Dr. Detmer say—that there existed a physician surplus, which should be addressed by restricting opportunities for residency training, a concern that had, for a very long time, focused heavily on New York because the State trains 15 percent of the nation's residents.

Our chief worry was that the loss of Medicare reimbursement in any voluntary downsizing or mandated downsizing would cause real harm to New York's very fragile health care system, because though 100 percent of the Medicare reimbursement is lost for each resident position cut, 100 percent of our cost is not.

That is because resident physicians are not merely helpers in the care process. They perform an extraordinarily important range of patient care services, most particularly for uninsured patients or those covered by Medicaid. In fact, in the city of New York, they are the backbone of the care system for those populations.

Although this is generally true of teaching hospitals around the country, nowhere is the problem of the magnitude as it is in New York. Forty-eight percent of New York City's population, 3.5 million people, are either uninsured or on Medicaid.

These patients, by and large, cannot afford private care in a doctor's office or in a hospital, and teaching hospitals have—for years—filled this gap through training programs in which carefully supervised residents provided their care.

When resident positions are eliminated, the patient care needs formerly met by those residents and for which there are no other sources of payment are exposed. It was this problem that led us to propose the demonstration, because we saw it as a way to model a workable solution and create crucial time and resources that could allow teaching hospitals, on a voluntary basis, to phase down their training programs.

I would like to stress a few important points about the demonstration. The cuts are real. HCFA will carefully model each year's resident count. If we do not make the yearly resident reduction targets, we will lose the partial reimbursement we would have received in that year, and if we do not meet the final targets, we will have to pay all of the dollars back.

Second, these reductions cannot be taken at the expense of training programs in primary care, which must increase or stay the same. Third, although the project imposes strict parameters, teaching hospitals and their faculty will be free to make their own decisions about how best to meet the criteria and adjust their academic missions.

Fourth, although the project does not specifically target reductions in international medical graduates, which is a policy we strongly oppose, we believe that American graduates will continue to be more competitive for the smaller number of positions, and the practical result may well be a reduction in international medical graduates. That will be a major topic for the evaluation of the study.

Finally, we believe that although the demonstration project is not perfect, we see it as a real opportunity to explore ways to respond to a national concern about physician oversupply and to achieve Medicare graduate medical education savings through a process that permits us to continue to meet the needs of vulnerable communities. Thank you.

The CHAIRMAN. Thank you, Dr. Foreman.

[The prepared statement of Dr. Foreman appears in the appendix.]

The CHAIRMAN. We are pleased to have you here, Mr. Muller.

STATEMENT OF RALPH W. MULLER, PRESIDENT, UNIVERSITY OF CHICAGO HOSPITALS, CHICAGO, IL, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. MULLER. Thank you, Mr. Chairman. I am from the University of Chicago, but I am here also representing the Association of American Medical Colleges. And seeing Senator Moynihan and Senator D'Amato here, I am a New Yorker, so I would like to take anything I can get here today.

[Laughter.]

Mr. MULLER. I see Dr. Foreman here. I grew up right in his backyard, at Montefiore.

This morning I would like to suggest two steps that will improve the future of American medicine. The first is establishing a shared

responsibility approach for financing the special missions of teaching hospitals and medical schools. And the second is, as you have heard before, is removing the special payments from the calculation of Medicare managed care rates.

Finally, I would like to address reducing Medicare payments for graduate medical education.

This committee recognizes—and many of you have been in the front of this movement—that teaching hospitals face unique and potentially devastating problems in the current price competitive environment.

During the last session, Senator Moynihan offered a specific proposal to fund the costs related to medical education and has introduced it again in this Congress. The AMC strongly supports this bill, and I wish to thank him publicly for his initiative.

This bill would establish a trust fund, with shared responsibility from three sources of revenue in assessment on private sector health insurance premiums on Medicare and on Medicaid. The AMC supports this trust fund concept as a means of assisting both teaching hospitals and medical schools.

Like teaching hospitals, medical schools rely increasingly on clinical income to support their education and research missions. Clinical practice is one of the few discretionary sources of revenue for underwriting innovative teaching programs such as you heard from Dr. Crittenden and for providing the seed money for new research activities.

In this price competitive managed care driven environment, the reduction in clinical revenue threatens medical schools' financial stability and their ability to foster the education or research missions for which not just all Americans benefit, but I think many of us would say that the medical schools and teaching hospitals really are the crowned jewels of the American economic system as well.

To our knowledge, Senator Moynihan's bill is the only bill that would provide funds for medical schools to replace their loss of clinical revenue.

The AMC recognizes there are at least two rationales for the creation of a trust fund. One is that it serves as a replacement funding to emirate the impact of reductions in Medicare, IME and DME payments.The other rationale, which Senator Moynihan and AMC emphasize, is the restoration of dollars that Medicaid and private payers have contributed in the past.

As part of shared responsibility, the AMC believes that Medicare should contribute to a trust fund on behalf of beneficiaries enrolled in risk plans. Therefore, we strongly support the IME, DME and DSH payments; removing them from the calculation of the AAPCC and paying them directly to teaching and DSH hospitals when they serve risk plan enrollees.

Congress designed those payments for specific policy objectives. Additionally, both ProPAC and the PPRC have said carving them out would improve the HMO formula to reflect more closely the actual cost of providing care to these enrollees; and therefore, as a centerpiece of this GME financing, Medicare can set the standards for participation. It should continue its vital role on behalf of fee-for-service and managed care enrollees.

The AMC understands the difficulties the Congress faces in extending the solvency of the Part A Trust Fund that Senator Gramm spoke to this morning, and hopes that any reduction in teaching related payments would be proportionate to other decreases in Medicare spending, implemented gradually and the impact monitored closely.

While many have pointed to high PPS margins as justification for reducing IME and DME payments, teaching hospitals are fragile. Their total margins continue to be lower than those of other hospitals, and this is a very important point. We lost money on Medicare patients when all revenues and costs are considered.

Because of IME and GME we have been well and better paid on inpatient payment. But when you look at total Medicare payments, we lose money on Medicare payments.

Finally, the association supports changes in GME payments to encourage primary care and ambulatory training. Again, this was spoken to before. Allowing DME funding to fall directly to the entity that incurs the cost, and counting the time that residents have spent in non-hospital settings, the IME payments are very positive steps to GME reform.

Thank you for the opportunity to be here, and I too will be glad to answer any questions.

[The prepared statement of Mr. Muller appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Muller.

According to data provided by ProPAC, Medicare pays teaching hospitals very well. I direct this question to you, Mr. Muller.

Mr. MULLER. Yes.

The CHAIRMAN. In fact, major teaching hospitals make a great profit, purportedly, on Medicare. In 1995, ProPAC found major teaching hospitals had an average of an 18.6 percent margin on Medicare patients. But these same teaching hospitals also tend to have the lowest total margin from all other payers. So this means Medicaid is, in fact, subsidizing non-Medicare patients. Do you care to comment on this? Is this appropriate?

Mr. MULLER. As my testimony indicated, while Medicare does provide more payments in the inpatient setting, as a result of the payments that are under consideration today, the IME and GME, the total Medicare payments to teaching hospitals, in fact, do not cover cost.

So while the margins may be higher, as suggested in the ProPAC study on inpatient care, when one adds inpatient and outpatient together, hospitals lose money on Medicare.

Second, as your question pointed out, the total margins for teaching hospitals are more in the 3.5 percent range, which is well below the margins for other hospitals. We, therefore, would welcome other payers supporting graduate medical education, as Medicare has in the past. Medicaid has done less of that.

For example, in my State of Illinois, Medicaid does not pay at all for GME. In many states it does. Medicaid in Illinois does not pay for GME.

So we would like, therefore, through our shared responsibility approach, to have Medicaid and other payers pay as well, as Senator Moynihan's bill would provide; and therefore, we would have

Medicare, Medicaid and all of the payers sharing more responsibly in the support of graduate medical education.

The CHAIRMAN. You do say, in your own statement, that the average PPS inpatient margin for major teaching hospitals increased to 18.6 percent in 1995, while their average total margin was 3.7 percent.

Mr. MULLER. Yes. But the PPS margins are calculated on inpatient activity. Many of our hospitals, whether it is the hospitals represented here at the table today or the 125 academic hospitals in AAMC, the 450 hospitals that are teaching hospitals—run major inpatient and outpatient programs. Medicare supports the cost of many outpatients as well.

So when you add inpatient and outpatient payments together, we lose money. We acknowledge the numbers on the inpatient programs that you have cited. In fact, over the years, especially the last 10 or 15 years, there has been appropriate—we think—support of GME within the Medicare inpatient program. When we look at total Medicare payments to teaching hospitals, we lose money on that.

So it is the total Medicare payment that we would urge this committee and the Congress to be look at.

The CHAIRMAN. This is a matter we will want to explore further.

Mr. MULLER. Thank you very much.

The CHAIRMAN. This is a question for all members of the panel. The consensus statement agreed to by AAMC and AAHC talks down aligning the number of residency positions with the number of U.S. medical school graduates.

At a hearing last week, the Chairman of the American College of Surgeons proposed that the total number of resident physician positions in teaching hospitals be reduced to about 110 percent of the number of U.S. medical school graduates. Or perhaps, 6,000 fewer residents than currently.

I would like to know what you think of this number of residency positions? And would this be an appropriate number of residents for Medicare to support through GME payments?

Dr. DETMER. Well, I would be happy to start this response.

The CHAIRMAN. All right, Dr. Detmer.

Dr. DETMER. From the point of view of the Institute of Medicine, it did not set a specific number, but it clearly thought the number ought to be very close to the U.S. output, but with some add-on. Similarly, the consensus statement did not come out with the precise recommendation.

But clearly, COGME, for some years, has talked about 110 percent, and Dr. Vladeck mentioned some were 110, 120. And it is hard, admittedly, to set target ceilings. It is a tough way to do it. On the other hand, the concern is that because the pipeline is so long, and the supply right now is so high, that we will be in real trouble down the line.

The CHAIRMAN. Dr. Crittenden.

Dr. CRITTENDEN. Two brief comments. One is that for most rural communities and for most, I will say, community based programs, I think there would be no real problem with a limit. In fact, it will probably be a reasonable thing. We do have too many people being trained.

The second question then is do we have other policies to insure that, in fact, programs that are community based can be developed, that is a second piece to that same question. I think everybody is in agreement that there are probably too many people being trained and they are not going to the right places.

The CHAIRMAN. Dr. Foreman, do you care to comment?

Dr. FOREMAN. The Greater New York Hospital Association does not have a position with respect to the appropriate number of residents that ought to be trained nationally.

As Senator Moynihan knows, I personally have felt, for quite some time, that the concern about the growing numbers of physicians in this country is misplaced; that, in fact, there are a very significant public benefits that have been and are being derived from a growing physician manpower supply.

But, quite frankly, as I sat on Dr. Detmer's task force and argued that position to no avail, and then had the privilege of serving as the chairman of the Association of American Medical Colleges and arguing that position there to avail, I ultimately concluded that either I or the argument lacked something in persuasiveness.

And so, from our perspective, the New York experiment was created in anticipation of a national policy which adopted some limit, those being talked about in a number of studies is 110 percent of U.S. medical graduates.

From my perspective, that number is not one which I can support personally, but it is certainly not irrational or unreasonable.

The CHAIRMAN. And finally, Mr. Muller.

Mr. MULLER. We support the consensus statement that Dr. Detmer spoke to. Thank you.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Sir, I came late.

Senator D'AMATO. No. No. I yield to Senator Moynihan.

Senator MOYNIHAN. I would like to thank Mr. Muller for his remarks about our bill S. 21, and give a little background, as much for the record, as I think these doctors know it, but as sort of a nice little fact.

In a course of a year-long hearing on the President's health care measure, which had these limitations in them, there came a moment when there was a professor from Fordham, which is also up where Montefiore is, or thereabouts, who said something which had was a wonderfully clarifying idea.

We were beginning to encounter this phenomenon of managed care, which we had not dealt with it and were not aware of it. He said, "What are you seeing is the modification of medicine." That is a wonderful image.

If you remember, we went for a century about labor is not a commodity, and the Clayton Antitrust Act of 1914 says so.

Then, from down the table where Dr. Foreman is sitting, the then head—I suspect he still is—of the UCLA hospital in Los Angeles said, "Can I give you an example? In souther California we now have a spot market for bone marrow transplants."

And suddenly, you realized that in this setting of economic rationalization, that there would be large benefits to be got out of this, as you would expect, but there would be problems. And they

would arise with the teaching hospitals and the medical schools that go with them.

And if we did not take care to provide for these institutions that would not "survive" in a purely economic competitive situation, we would end up doing great disservice to ourselves. Hence, the idea of a tax called a tax premium on health insurance and a trust fund.

At one point in our committee—this will be 2 Congresses ago, Mr. Chairman—the motion was made to strike that provision in a bill that we reported, and it failed 13 to 6 in this body. It was a 2 to 1 judgment. I hope we can pursue it.

Could I ask if anybody wants to comment? It is generally the case that given an economic rationalizing, out of the benefits that comes from that, we have to provide basic science and teaching.

Mr. MULLER. I would say, even at the University of Chicago, we believe in public goods.

The CHAIRMAN. In some departments. Yes.

Mr. MULLER. In some departments. [Laughter.]

Very strongly in the hospital. I think the Congress took a great step back in the early 1980's by funding GME through the IME, the DSH and the DME allowances.

In Medicare managed care, however, these payments are not given to hospitals. They have come out of the Medicaid programs in many parts of the country. As I mentioned, Illinois, does not pay for GME in Medicaid.

And as the big insurance companies all turn from indemnity plans to managed care plans, as they all buy and sell each other, GME gets thrown out. So obviously there is a market thrust in health care these days that is having very powerful effects.

But we are getting run over in the teaching hospitals and the medical schools, and therefore, we are urging—through the shared responsibility fund and the AAPCC carve-out—that we support graduate medical education, rather than allowing this commodization in these spot markets that we, therefore, have shared responsibility and we have these carve-outs as a way of protecting these very important institutions and the people that we serve in these institutions.

Dr. DETMER. I would assure you that Mr. Jefferson's University is also supportive of public goods. So certainly, at the individual level and from the point of view of our institution, I think there is enormous appreciation and support for the concept you are talking about.

I think Academic Health Centers, as an organization, agrees with that as well and is appreciative. And I think the other comment that I might make as well is obviously physician workforce does not exist in a vacuum.

There are a lot of health professionals, and I think the issue is that—I think your strategy really allows us to look at regional needs, as well as workforce distribution, in a general sense, and also do the important issues of research and continuing discovery and such.

Dr. CRITTENDEN. Maybe a couple of real quick comments. One is it is a public good. Our State went through a process 2 years ago. We actually proposed reform within the state. Because of a number

of different things, it was not adopted; a similar thing to your shared responsibility idea.

This is a public good. It is certainly not being financed as a private good right now. In our experience in our State and our teaching hospitals, we have yet to get one contract from a managed care entity that actually recognizes education as a reasonable issue to reimburse explicitly, despite numerous discussions.

Dr. FOREMAN. We thought so much of the idea, Senator, that when the Senate Finance Committee voted it down 2 to 1, the legislature in Albany passed it for the State of New York in a different form. As you know, non-Federal payers now do, through a system of State sponsored financing, pay for graduate medical education in New York, outside of the managed care payment stream, and it is working wonderfully well to protect the educational interests of New Yorkers.

Senator MOYNIHAN. I would just like to say, I think we have a conceptual understanding of this, and I make it clear that this was action by this committee. Senators Danforth and Durenberger were particularly interested in it. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Thank you, Mr. Chairman. First of all, let me say that I am particularly pleased to see Dr. Foreman, and I want to congratulate him—he is a friend—for his stewardship and leadership at the Montefiore Hospital and the great teaching facility, Albert Einstein, and all that it does. I am talking about serving one of the most under-served populations.

Dr. Crittenden talks about the under-served in the rural area, and we have those too in New York. So this should not be an either/or, and I want to say that Dr. Crittenden recognized that; that there are special needs in our urban centers and rural, and we really should work to recognize those together.

And I was very pleased to hear that it was not a taking from one to help the other, but rather, a recognition. And indeed, to place caps in the rural areas in particular, I think would be devastating. You just cannot do that. And the dollars saved would be minuscule in the totality.

And yet, where you have these needs, and very special needs, as we do in the urban centers, the greater Montefiore Center is the primary care provider for a million and one-fourth people in the Bronx. Many of them are at the lowest levels, in terms of the most vulnerable population, having no health care, other than in this great institution. No insurance funds.

It probably has one of the highest, in terms of major metropolitan areas, in lack of insurance. And it is particularly difficult for those who do not qualify for Medicaid and fall right in that middle, in the middle area where they earn enough not to qualify for Medicaid and then do not have insurance besides.

And again, to the New York Hospital Association, Dr., I think that the plan that you have come up with and that you got out ahead of the curve demonstrates the kind of thoughtful process that we need, because you are not saying we want to do business as usual.

We are not saying we want to keep every dollar that we get, but we are ready to entertain a program that will give us a sufficient time and cushion, and in the end, result in savings to the Federal taxpayer, as well as giving New York and others an opportunity to see how this works and giving the discretion of allocating the cuts to the institutions themselves; to the universities and to the medical facilities.

I just think that is the way to do it. We all talk about not imposing mandates on States, et cetera, and yet, we willy-nilly in time to do that. Here, we are meeting goals and targets that the administration and others are talking about, the need to reduce. And the chairman is quite correct in attempting to reduce the number of foreign graduate students who come in and use our facility at a very high cost.

There is a very real sense out there that we should not be subsidizing this per se. And this program will, without targeting specifically the graduate of a foreign medical institution, undertake that, as Dr. Foreman has indicated.

And, Doctor, I wish that we had more members, and I hope that you take the opportunity and you get the occasion to present—in the manner in which you did so cogently—all of the aspects, and you summarized them, that the HCFA demonstration plan in New York brings about.

I only see a win/win. If it does not work, it does not cost the Federal Government one penny, and they have got to pay money back.

So, Mr. Chairman, I know that you have had the insight and were thoughtful enough to arrange for this hearing, and I want to commend you for that, because I think we have brought some clarity to this situation. It is so easy to say how come they are getting paid for nothing? Well, the fact of the matter is they are getting paid to undertake a program to really downsize and to share the savings that accrue with the Federal Government.

If we had more of that kind of innovative thought, we would be doing a lot better.

I just want to raise one question. Do I take it that there is a broad-based consensus that the GME payment carve-out that the administration has suggested is something that you all support? Mr. Muller.

Mr. MULLER. Yes.

Senator D'AMATO. Dr. Detmer.

Dr. DETMER. Yes, sir.

Senator D'AMATO. So that, would you allow some time to have this phased in so that the HMOs have an opportunity to adjust?

Dr. CRITTENDEN. One thing is that HMO penetration is growing rapidly. The more it gets transferred into their cost base, it is going to be more difficult to take out. So I just caution you on slowing it down.

Senator D'AMATO. Yes. Mr. Muller.

Mr. MULLER. Well, as you have indicated, these payments were put in there for a very specific purpose 15 years ago, and they should be kept for that purposes, rather than eroded. So we think the carve-out should be immediate.

Senator D'AMATO. Dr. Foreman.

Dr. FOREMAN. It is our feeling that, at least in some cases, GME payments are being used as a marketing inducement for managed care plans. That is to say they induce risk plan sales by making available benefits, which would otherwise not be available to Medicare beneficiaries because there is enough extra money in the AAPCC, which got there because its origins were either DME, IME or DSH.

Those dollars then get converted into benefits, which would otherwise not be available, as a means of stimulating sales of risk plans for Medicare enrollees. The Congress may want that to happen, but I do not recall it ever saying so. That is, to say these payments have their origins, obviously in support of graduate medical education or the care of the poor.

And for them to be rolled up in the AAPCC and then available for other benefits or for essentially retained earnings for the HMOs, I think is not consonant with what I understood the intent of Congress to be.

Senator D'AMATO. Mr. Chairman, thank you. I think that is an area we really should look at very carefully. It just seems to me that what we have is the HMOs taking advantage of these payments; not reimbursing, and I understand that they have not been reimbursing the hospitals for that. They have been very contentious.

So they are keeping the dough and not really sharing in the cost, and that is wrong. I find increasingly that there are a number of HMOs, unfortunately, that take advantage of our move to managed care.

Now, we want managed care, but this is another vehicle by which to make money, which they have not really provided that kind of protection for or helping to pay for it. So I think we should look very carefully, and I tend to be very supportive of that carveout. I think it would help all of our hospitals.

And I turn to my good friend here, Senator Grassley, because he has been a champion, a champion in terms of helping the rural medical providers, and this is an area where we could give them some help. I thank the chair.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman. As you know, I am chairman of the broader committee with broader jurisdiction. So when somebody is saving money, I want to know who, conversely, is losing it. So I am rather curious.

Dr. Foreman, you mentioned that 50 percent of the cost of the GME payment goes for salary, and 50 percent goes to the hospital. Now, if there is no resident, does the hospital just lose that money?

Dr. FOREMAN. Yes. Right now, the direct and indirect medical education payments pay for a whole host of things. But the direct medical education payments pay for the resident's salary. They pay for the directly ascribable educational costs; the cost of faculty, the cost of teaching facilities, and a piece of the direct medical education payment pays for the institutional overhead.

And the indirect medical education payment is derived from a complicated formula, which does not compensate in quite the same way for direct costs, but rather, for the observed and measurable costs that teaching hospitals accrue that are not present in non-

teaching hospitals, but are not as institution specific as the direct medical education payments are.

Both of those payments, the direct medical education payment and the indirect medical education payments disappear, with each resident reduced and, obviously, increase with each resident added.

Senator JEFFORDS. Well, do we presume that when there is no longer a resident at the hospital, the resident disappears into the unknown? Or does he or she end up somewhere else? And if so, what kind of payments are made?

In other words, I believe you testified that two-thirds of your residents are at hospitals.

Dr. FOREMAN. No, sir. If I did, the testimony is somewhat misleading. The residents are, in their educational experience, divided between inpatient facilities and outpatient facilities. Some of those outpatient facilities are owned or operated by the institution. Occasionally they are not.

Medicare will reimburse, presently, for care which is conducted either in an inpatient facility or in an outpatient facility which is owned or operated by a hospital. Where it does not pay is where residents were to rotate out into facilities which are not under a hospital's operating certificate; at a freestanding clinic.

Senator JEFFORDS. Now, is the Medicare payment for a resident at an inpatient facility the same as the payment for a resident at an outpatient facility which is owned or operated by a hospital?

Dr. FOREMAN. If the outpatient facility is owned or operated by the hospital, the direct medical education payments are the same. But the indirect medical education payments only run off of the residents that are in the hospital at any given time.

So, as a result, if 90 percent of the residents were in inpatient facilities and 10 percent were at outpatient facilities, you would get 100 percent of the direct medical education and 90 percent of the indirect medical education payments.

Senator JEFFORDS. I would like to understand where the savings occur. Ultimately, are there fewer residents in the State of New York?

Dr. FOREMAN. I am sorry. You mean in our project.

What happens now is that if we were to voluntarily eliminate a resident, we would lose the resident and all the payments associated with it. So we would lose the resident's cost, which would be whatever his or her salary and benefits would be, but we would have the residual cost left in. All we would do is lose the payment for it.

What the experiment does is it permits us to keep a portion of the dollars we would ordinarily lose through the 5 or 6 years of the project, and that gives us some additional cash for which we do not have a direct expense of the resident. But we still have a lot of the other expenses that have to be paid; to offset those expenses and to find substitute providers to deliver services to the uninsured and the Medicaid patient who previously had been cared for by the resident.

Senator JEFFORDS. Thank you, Mr. Chairman.

The CHAIRMAN. I might mention—I think it was last Saturday—there was an Op Ed piece in the New York Times by a resident at UCLA's Medical Center.

This young doctor contended that the combination of Medicare GME subsidies and the squeeze on teaching hospitals from managed care has resulted in residents being viewed as cheap labor; that residents actually do a lot of routine tasks done in other hospitals by nurses and others. ProPAC, as I understand, made some similar observations.

Now, this doctor suggested eliminating Medicare GME subsidies, saying it could have two good effects. First, it would push managed care plans to pay more for teaching hospital care. Simply to be competitive in signing up enrollees and eliminating Medicare GME subsidies could improve doctor training by allowing residents to focus on patient care.

Do any of you care to comment on this editorial?

Mr. MULLER. I found his argument—this seems to be the Marie Antoinette School of Economics, "Let them Eat Cake"—that the people who have been paying for graduate medical education in the past, that is, Medicare, should now stop that and that should be put on to the people who show no willingness to pay for it, which is the managed care companies.

So I think he needs a few courses beyond what he has currently gotten. I found his argument quite perverse.

The CHAIRMAN. You do not think market forces would work?

Mr. MULLER. Well, market forces are working to drive out the support of GME, and that seems to be what was missing in his argument. I think we all have conceded that shared responsibility requires some kind of collective solution, and the market forces are always going to try to buy at marginal costs.

So his solution would drive under the school that he is working at, I would think.

Dr. DETMER. I would like to follow up on that, too. I think he also underestimates the real costs that are involved in producing the kind of health care expertise this Nation enjoys, both in terms of its research, not just education. The IME issue also relates to this whole environment, and I think that was overlooked.

But it costs about $1 million to create a generalist and a $1.5 million a specialist. And unless you really had very, very wealthy students, there is absolutely no way, in the current climate that is very price competitive, that we would, in fact, have this capacity. At least that is my view on it.

Dr. FOREMAN. I was not at all surprised at the level of naivete a resident in training about health economics. I was astonished that the Times published that piece. It was the most ill-considered analysis of how graduate medical education costs were really generated and paid for I ever read.

And I think it did a considerable disservice, frankly, to this discourse because it created a null hypothesis that if nobody paid for graduate medical education, somehow or another, it would all improve.

Now, it is very difficult for me to see precisely how that would be carried out.

Now having reached my gray years, as you may have noticed, I came from an era in which training was conducted before there was Medicare and before there was Medicare support of graduate

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medical education, and I can tell you it was a mess. It was catch as catch can in many institutions.

Graduate medical education programs would never pass the level of scrutiny that they are now subjected to because they were inadequate as educational experiences. They were nothing but work experiences, unlike me this young resident could not possibly know that from his own experience.

There was a time in this country where residents did very little but work all day and all night. And if they learned something, that was considered terrific. And if they did not, that was their problem.

We now have a very elaborate system of graduate medical education, which, unfortunately, costs a lot of money. And if nobody pays for it, it will disappear, and that is the truth.

The CHAIRMAN. Well, I am surprised. I thought you would all agree with the editor. [Laughter.]

Mr. MULLER. Some things do not travel as well from the west coast.

The CHAIRMAN. We do have some additional questions, which will be submitted to you in writing, and we would appreciate your answer. Thank you, gentlemen, very much.

The committee is in recess.

[Whereupon, at 12:05 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT A. CRITTENDEN, MD, MPH

Mr. Chairman, members of the committee, it is a great pleasure to testify before you today. I am Bob Crittenden, Director of the Office of Education Policy for the University of Washington School of Medicine. I am a practicing Family Physician and am Chief of Family Medicine at Harborview Medical Center in Seattle. Apropos to the hearing today, I work with our affiliated residencies in Alaska, Montana, Wyoming, Idaho and Washington to ensure that these needed programs have the resources to continue their important educational mission.

Issues:

I would like to emphasize three points concerning Medicare Graduate Medical Education (GME) and the funding of residency programs that meet community needs. First, there is a need for programs that address the real provider shortages in rural and underserved communities and, contrary to some opinions, we can construct training experiences that do distribute needed providers to underserved communities. Second, these residencies depend on Medicare for baseline funding. Finally, the GME carve-out from the Medicare risk contracts is exceedingly important for community based programs as managed care moves into communities that are involved in training.

Background:

Before we begin these points I would like to describe our very unique medical school and the WAMI program. The University of Washington is the medical school for Washington State, and it is a regional medical school for four other Northwestern states -- Alaska, Montana, Idaho, and now Wyoming (see attached map). Besides being the medical school for these states, we support graduate medical education in all of the WAMI states through our affiliated residency network. We also provide a spectrum of support services that range from undergraduate education to health system development to ensure that we train physicians interested in working in rural and underserved

communities and that we have local health systems that can support these providers. Our education is diffuse and community based.

In the eyes of the legislatures and governors in our partner states, the success of our school depends on our ability to address the real health manpower needs in their states. The legislatures of Washington and the partner states look very closely at our performance and evaluate us on whether we are meeting their needs. Up to this time we have been able to address many of the physician needs in rural underserved communities. There are a number of reasons for this success.

We have focused on primary care programs in rural communities. Most underserved communities need local generalists and a few specialists. Almost all of our regional training in the WAMI area is focused on generalist training. This is not to say that we do not train specialists. On the contrary, we pride ourselves on training some of the best specialists in the country -- mainly in Seattle. I as a generalist want highly trained specialists to assist me in the care of my patients. The issue is not one of specialists versus generalists, but rather it is an issue of balance and focus.

To train generalists, we must consider a number of important facts. 1) Most physicians stay in the general area where they receive their training. 2) Residents who spend more training time in rural and underserved settings have a higher probability of working in these communities. 3) If physicians work first in rural communities, they have a much higher probability of remaining in rural communities. If they first work in urban areas they almost never end up working in rural communities. 4) From all measures, the quality of training provided in small town and rural settings matches that received in urban areas.

To respond to these realities, rural and underserved training opportunities have been developed in many of our network residency sites. The result is that about 30% of our network graduates work in communities of less than 10,000 people. Some very innovative programs, including those in Spokane and Billings, have significant rural training opportunities. In these programs, the residents spend the first year in the larger towns doing hospital and primary care. In the second and third years of their training, select residents move to rural communities to work in high quality family practices and return intermittently to the main residency for focused training. Almost all of the graduates of these programs eventually work in rural communities. Also, the residents who train in these rural training tracks compare favorably with their peers by all measures we have available. In other words, we have found that we can train people in rural communities who will work in rural communities and care for Medicare beneficiaries in these communities. To be successful, though, we need to have reasonably financed training programs in those communities.

So, how are these residency programs financed? I would like to use two examples. The attached pie chart outlines the revenue sources for the Family Practice Residency of Idaho in Boise and is an example of our mature residency programs. The chart describes the different financing streams that are needed to support a residency training program. This program has developed a productive clinic yet receives only about half of its income from patient revenue. The next largest source is labeled "Hospital." This is typically 20-35% of the income of a residency program. These funds come from patient revenue of the hospital and usually represent the Medicare GME funds paid to the hospital.

Start-up programs like the Alaska Family Practice Residency in Anchorage and the Montana Family Practice Residency in Billings are good examples of the crucial role of Medicare funding. These programs have been established by community based physicians, hospital administrators, and local leaders who recognize and want to solve

some of the health personnel needs in their communities and in their states. They have crafted support from the physician community, key hospitals, and community and political leaders. The directors of these programs have developed training opportunities in their main locations that are similar to family practice residencies elsewhere, and they have developed rural training sites in Bethel, Alaska and Glasgow, Montana where a subset of their residents will care for patients in those rural communities. These programs, now just beginning, are the first and only free standing residency programs in their states. We expect these residency programs to develop into the lead local programs to address the primary care provider shortages in their respective states.

When the programs in Anchorage and Billings were being developed, the hospitals in these communities had to make some very hard financial decisions about their ability to support the residency program. The revenue they projected from Medicare allowed the hospitals to finance these programs. Without these Medicare Graduate Medical Education funds, these hospitals would not have supported residency development. Indeed, the delay from start-up until sufficient patient volumes are built up requires a large up-front investment that many rural and small town hospitals are not able to consider.

Now there is a threat to the Medicare funds on which these programs and their sponsoring hospitals depend. That threat is coming from the increasing proportion of the Medicare dollar that is going to managed care organizations as the AAPCC capitation. The problem is that managed care organizations are receiving the education funds previously paid directly to the hospital and they are not passing it on to the training programs. In our experience, not one managed care organization has recognized education as a cost that needs reimbursement when contracting with teaching hospitals. This is a major problem. Not only do hospitals, and indirectly residency programs, get less funding as the market share of Medicare risk contracts increases, but the funds that are paid to the managed care

organization in the AAPCC earmarked for education funding are not going toward education. This redirection of Medicare GME funds to other uses is happening in Washington State now. While there is little Medicare risk contracting in the other WAMI states, managed care is just beginning and is expected to grow rapidly. Providers and educators in these states are very concerned about the future of this funding and this uncertainty is straining the relationship between programs and their sponsoring institutions.

The loss of a substantial portion of Medicare GME funding in many of our network of residencies could cause sponsoring hospitals to withdraw support. Past experience has shown us that when hospital funding is withdrawn, a family practice residency is no longer viable. We, therefore, want the United States Senate to seriously consider the proposals laid out by the administration and the AAMC.

Recommended Action:

The GME portion of the AAPCC should be removed from the calculation of the capitation rate. As proposed by the administration, funds excluded from these payments should be placed in a trust fund for the continued funding of education. There is broad agreement by many groups in Washington DC and outside that this carve-out is important, and there are good policy reasons for making this shift. From the perspective of the programs in our region that train people to work in rural communities, this shift is essential.

The administration efforts to reform GME would mostly be of benefit to community based education. Specifically:

- The proposal to count the work of residents in non-hospital settings would provide greater equity for community based training and enable appropriate funding levels.

However,

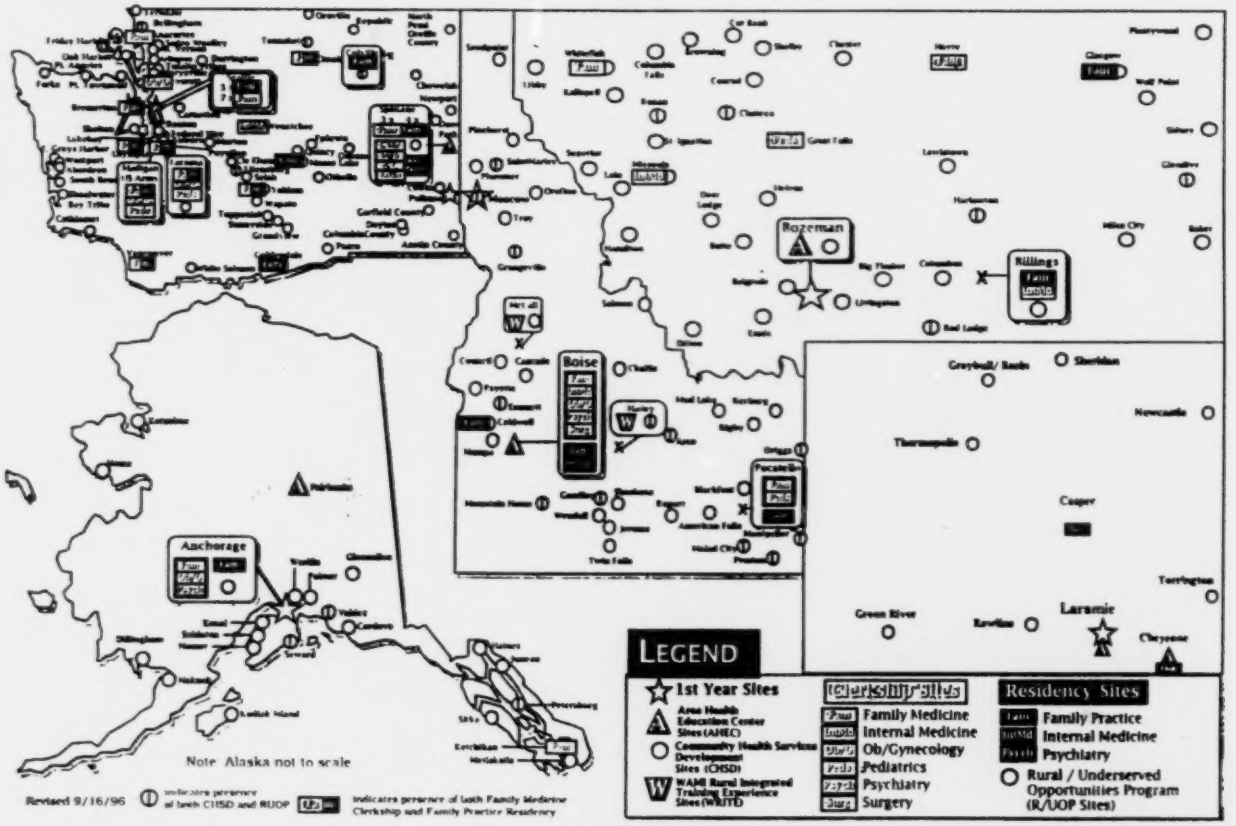
- The cap on growth of residencies should not pertain to programs that train people to work in rural and underserved communities. The Administration proposal includes a cap on the number of residents on a hospital by hospital basis. While we have enough residents in Seattle (and there are market pressures to decrease specialty training programs there), limiting the growth of residency training in rural states that are grossly under-represented in residency training doesn't make sense.

If a trust fund is established, support should be available for new programs that meet the needs of rural and underserved communities. Watching the struggles of the program directors in Montana and Alaska as they establish their programs with few resources highlights the need for fund availability to start needed programs.

While the focus should now be on the carve-out and the establishment of a trust fund, many people in our region want to ensure that programs that train people to work in rural and underserved communities have equitable access to these trust funds. We agree with the recommendations of the AAMC, AAHC, the AMA and other medical organizations that as policies are made to use federal funds most effectively, the needs of rural and inner-city communities should have priority.

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

WAMI Program Site Maps



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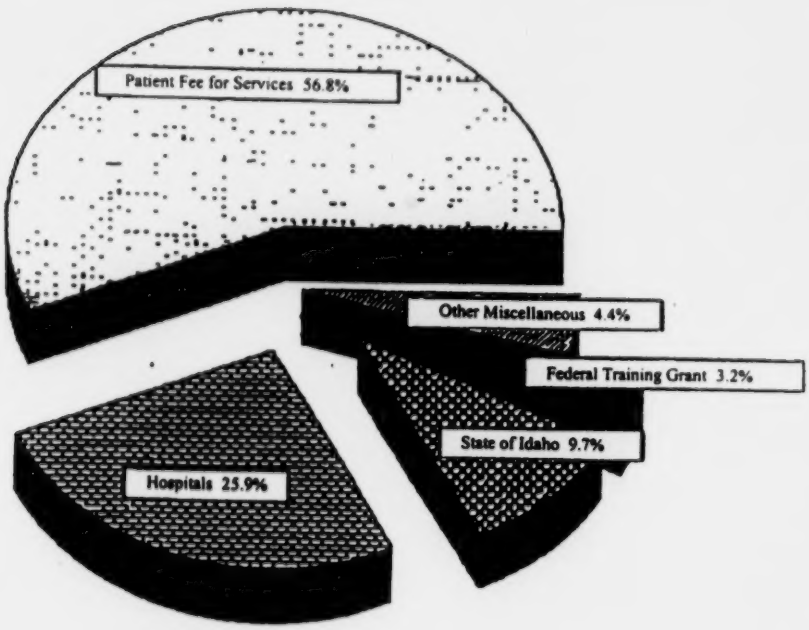
Family Practice Residency of Idaho

Revenue Sources



James Blackman, M.D. 1996

Options for Balancing Physician Supply and Requirements
Statement by
Don E. Detmer, MD[1]

March 12, 1997

Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to present the results of two efforts related to balancing the physician workforce in this country. In essence, I am wearing two hats today. The first is co-chairman with Neal Vanselow of the 1995 Institute of Medicine (IOM) study of physician supply and requirements in the United States.[2] The second is a representative of the Association of Academic Health Centers (AHC), one of six organizations that recently issued a Consensus Statement on the Physician Workforce. My statement today consists of brief remarks about the IOM; a summary of the IOM study's findings, conclusions, and recommendations for policy action; an overview of the physician workforce consensus statement; and perspectives from the AHC on the physician workforce.

The Institute of Medicine, and Background on the Study

The IOM is not a governmental agency, but rather is an independent, non-profit organization, chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public. Committee members are volunteers who are selected for their expertise and not their institutional affiliation. The Institute acts under both the Academy's 1863 congressional charter responsibility to be an adviser to the federal government and its own initiative in identifying issues of medical care, research, and education. For example, the IOM in 1993 advocated universal access to basic health care benefits for all Americans. Unfortunately, its advice on this issue remains unmet.

As the twenty-first century draws near, the size and composition of the physician workforce trouble both health professionals and policymakers, particularly because of the radical, rapid, and unpredictable transformation of the health care delivery system. With the collapse of efforts between 1992 and 1994 to enact comprehensive health care reform, much of this restructuring is taking place through changes in the private sector, with-as yet-unforeseen consequences. An ongoing debate is anticipated about how many and what mix of health care personnel the nation needs and judges affordable.

The IOM concluded that a brief review of data on aggregate supply and requirements and an examination of options for dealing with the physician workforce would be valuable, and it appointed an expert committee to carry out a short but substantive review of existing data about the U.S. physician supply, to identify positive and negative implications of the possible mismatch between supply and requirements in coming years, and to lay out possible options for addressing any perceived problems.

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[1] University Professor and Senior Vice President, University of Virginia.

[2] The committee comprised a diversity of views and disciplines, including medicine, economics, law, health policy, and health services research. A list of the members of the Committee is attached to this statement.

During the spring and summer of 1995, the committee reviewed a wide range of materials on these issues; it met once to discuss the issues and come to consensus on conclusions and recommendations. The committee ended its deliberations with **three principles**.

- First, the nation should separate national workforce policy for graduate medical education from the service delivery needs of selected parts of the health care system.
- Second, long-term physician workforce policy should be driven by aggregate requirements nationally, and meeting those requirements should be cued more to the output of U.S. allopathic and osteopathic schools than it is today.
- Third, opportunities in the United States for careers in the healing arts, such as medicine, should be reserved first for graduates of U.S. schools.

Summary of Findings and Conclusions

Most studies of the adequacy of the physician workforce for the past 15 years have concluded that **the United States already has or will soon have an oversupply** of physicians, generally characterized as a large surplus of mostly nonprimary care specialists and either a shortage or relative balance in the supply of primary care physicians. Workforce experts often characterize physician supply in terms of total active physicians. In 1970, the United States had a total of 308,487 active physicians (both allopathic and osteopathic), or a ratio of 151.4 physicians per 100,000 population; in 1992, the respective figures were 627,723 and 245.0, which represented an increase in the physician-to-population ratio of about 62 percent. Another important number involves active physicians in patient care (excluding those in training). In 1970, the figure was 222,657, with a physician-population ratio of 109.2 per 100,000; two decades later, the number was 461,405, giving a ratio of 180.1 physicians per 100,000 population in that year (an increase in the ratio of about 65 percent).

These figures can be interpreted in light of a landmark report in 1981 on the adequacy of the U.S. physician workforce from the Graduate Medical Education National Advisory Committee (GMENAC). Its estimating techniques forecast a supply of nearly 536,000 professionally active physicians in 1990 and nearly 643,000 in the year 2000--for physician-to-population ratios of 220 and 247, respectively, per 100,000 persons. GMENAC concluded that the nation could expect to have a surplus of physicians in the future (not a shortage) and that the surplus would grow from 70,000 physicians in 1990 to 145,000 by the year 2000. Looked at another way, for the past two decades the U.S. physician supply grew at one and one-half times the rate of growth of the general population. Clearly, by the mid-1990s, the nation was well on its way to surpassing the GMENAC predictions.

Graduate medical education (GME) plays a significant role in U.S. physician supply because, following graduation from medical school, doctors in *graduate* training (interns, residents, and fellows) provide considerable patient care and because GME is the necessary pathway to a medical career. More than 99,000 physicians were in graduate training in 1992. Since 1988-89, the numbers have increased steadily at about 4 percent per year. More than 108,000 physicians were in GME training in 1993-1994 as compared to fewer than 85,000 in 1988-1989. The rise in these GME figures is explained by three factors:

- Physicians in residency training are a source of financial support for hospitals through the current incentives and mechanisms of GME payments from the federal government.
- On average, residents remain in training longer than they once did.
- In large part, the increasing numbers of residency positions are occupied by growing numbers of international medical graduates (IMGs).

The number of U.S. medical graduates (USMGs) in GME training has remained stable since the early 1980s, but between 1988 and 1993, the number of IMGs in residency or fellowship training increased by 80 percent (from 12,433 to 22,706); the number of IMGs in first-year residency positions grew by more than 3,200 between 1988 and 1993, whereas the number of USMGs declined by nearly 230 individuals. The vast majority of IMGs are not born in this country but instead are foreign born (generally termed FNIMGs, to include non-U.S. citizens, naturalized citizens, and those of unknown citizenship); as many as 75 percent of the FNIMGs who take their residency training in the United States will remain in, or shortly return to, this country to practice. In short, the issue of the long-term match between the supply of physicians in this country and the expected requirements for physician services cannot be addressed without consideration of the role of GME and the role of IMGs within GME.

This committee was not unanimous in labeling the current number of physicians as an absolute oversupply or excess, for two reasons: (1) the need or demand for physicians is better understood as requirements for physician *services*, and (2) the idea that a surplus exists (or does not) is best settled in the context of explicit assumptions about the goals and characteristics of the health care system now (and in the future) and about different ways in which those goals might be met. Rather, the committee concluded that

- the nation, at present, clearly has an abundant supply of physicians--which some members of the committee were prepared to label a surplus;
- judgments about the implications of those numbers must be made in the context of the overall U.S. health care system and the components of that system of greatest concern—the quality and costs of health care and access to services;
- the increase in the numbers of physicians in training and entering practice each year is sufficient to cause concern that supply in the future will be excessive, regardless of the assumptions made about the structure of the health care system; and
- the steady growth in numbers of physicians coming into practice is attributable primarily to ever increasing numbers of IMGs, about which the committee is very concerned.

Relationship of Physician Supply to Key Elements of the Health Care System

Will the current or anticipated numbers of physicians have, on balance, positive or negative consequences for costs, accessibility, and quality of health care in the nation? Will that supply have beneficial or harmful effects on such matters as the efficient use of human resources and the long-term future of the nation's academic health centers? Will these judgments differ depending on where the U.S. health care system ultimately settles on a spectrum from tightly controlled capitated managed care to loosely controlled fee-for-service medicine? The committee's review of data and published materials, discussions with physician workforce experts at its July meeting, and further deliberations led it to conclude that an oversupply of physicians in this country poses more problems for, than solutions to, the nation's health care issues. Taken as a whole, the literature on empirical inquiries into the relationship between the

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overall supply of physicians (on the one hand) and phenomena such as access to health care, quality of health care, and its costs (on the other) is, unfortunately, quite ambiguous. Among the points to be emphasized are the following:

- The temptation to argue that a physician oversupply might have a beneficial impact on costs, access, or quality should be resisted. Such an assertion does not stand up to scrutiny. Our Nation's record in addressing these issues, even with a dramatically increased supply of physicians is far from adequate. For example, an oversupply will not have much effect on problems of access to care in this country; an abundance of physicians has not so far and will not solve the problems of maldistribution by geographic area or specialty. One cannot demonstrate that a surplus will improve the quality of patient care; in some scenarios, it may dilute quality, and a surplus will contribute to higher aggregate health care costs at least as long as the nation has a significant fee-for-service sector.
- Having far more physicians than needed to meet the nation's requirements is a waste of the federal resources currently spent on physician graduate education, and it may also be a poor personal investment on the part of prospective medical students. When individuals pursue a medical career in the face of a significant oversupply of physicians, their underemployment or underutilization is a tremendous waste of human resources for them and for the nation.
- Use of large numbers of IMGs here lowers opportunities for able young persons from the United States to enter the medical profession, particularly underrepresented minorities and women, and some might argue that it also deprives the citizens of other nations of their own talented youth.

Thus, the committee believes that however a better balance is to be achieved, it is in the national interest to avoid a serious oversupply of physicians. If the nation had to choose today between too many physicians and too few, it would prefer an excess to a dearth, but little appears to be gained from a huge imbalance between supply and requirements, especially if circumstances adverse to cost, quality, or access were to result. The committee agrees with this assessment—recognizing that an accurate balance between physician supply and societal requirements is an unachievable goal and generally favoring too many rather than too few physicians.

The net effects of very high numbers of physicians over time are difficult to predict. The interactions of the underlying forces that shape the U.S. health care system are complex and evolving; in particular, the influence that the managed care revolution will exert is uncertain (although a physician surplus might speed the move toward better managed care). Furthermore, good data on patterns of production and employment of the entire health care workforce, as they relate to these systemwide changes, are sparse.

Nevertheless, the committee believes that, on balance, the large and rising numbers of physicians in this nation can have some negative consequences. Apart from those just noted, a physician surplus could seriously demoralize U.S. physicians or further complicate the future of academic health centers. Predicaments such as these will be far more difficult to address and resolve in the future than they are today. For this reason, the committee advocates action on several fronts to moderate current growth in the U.S. physician supply and to forestall the

potentially deleterious effects of unfettered increases. Some concrete steps need to be taken, and they need to be taken soon, since the medical education process is such a lengthy one.[3]

Strategies for Addressing Physician Supply Issues: IOM Recommendations

Three categories of strategic choices were discussed by the committee: an extreme laissez-faire approach; a strong regulatory program; and a regulated or planned market strategy. In the end, the committee in toto did not embrace the two extreme positions (all market, all regulatory) because those were viewed as too unlikely to be practical and adopted. Rather, the committee examined several "constrained market" steps and reached five policy recommendations.

Producing Physicians from U.S. Medical Schools

The committee concluded that increasing the number of students at U.S. allopathic and osteopathic medical schools would be unwise public policy; the nation clearly graduates a sufficient number of physicians today. It opted for a steady-state approach to undergraduate medical education. Specifically, **the committee recommends that no new schools of allopathic or osteopathic medicine be opened, that class sizes in existing schools not be increased, and that public funds not be made available to open new schools or expand class size.** Maintaining, but not increasing, the current number of medical graduates, especially if more minorities are brought into the student bodies, was judged to be the most appealing short-run strategy for undergraduate medical education. Keep in mind that applications to U.S. medical schools are at historically high levels.

Although some downsizing might occur over time, the committee has not advised specific action in this direction, for various reasons. First, in the 1960s and 1970s, public policy and government programs led to an overexpansion of U.S. schools and class sizes, and this contributed to a significant increase in physicians who remain in practice today. However, the number of physicians graduating from U.S. schools has now stabilized at a level that seems consistent with likely requirements and the nation's ability to absorb them. Second, recent increases in the number of residents in training are due almost exclusively to increases in IMG trainees. Because 75 percent or more of IMG residents remain in, or return to, the United States to practice, these increases will result in continued growth in the nation's physician supply. No persuasive rationale can be put forward for leaving the incentives and openings in place for IMGs to practice in the United States while curtailing the opportunities for the nation's own youth to enter a distinguished profession. Third, closing medical schools or reducing class sizes might well undermine efforts to bring more minorities into the profession.

Revamping Graduate Medical Training

The present system of Medicare reimbursement for residencies through direct and indirect medical education (DME, IME) payments is a major incentive for teaching institutions to keep their numbers of residency positions high and expanding. One part of the solution to potential oversupply problems in the future is to revamp the ways in which federal programs support

[3]The educational process can be as long as 11 years following completion of an undergraduate college degree, and thus career choices taken at the beginning of a baccalaureate program would take 15 years to reach fruition.

GME. In keeping with the principles stated earlier and the committee's concerns about the growing number and proportion of IMGs in the nation's physician supply, **the committee recommends that the federal government reform policies relating to the funding of graduate medical education, with the aim of bringing support for the total number of first-year residency slots much closer to the current number of graduates of U.S. medical schools.** Specifically, the committee believes that the government ought to limit the number of GME positions that it funds through the Medicare program and that this limited number of residency positions should be available first to physicians who have graduated from U.S. medical schools.

These basic ideas are not especially new. In 1995, two groups, the Council on Graduate Medical Education and the Pew Health Professions Commission advanced similar ideas, as did the Prospective Payment Assessment Commission.

The nation's current mechanisms for underwriting GME costs have some perverse effects because the link between payments for service and GME creates incentives for hospitals to establish more and larger residency programs and to fill them with whoever is available, especially IMGs. Because the country's present approach--open-ended GME support to hospitals for their residency positions--offers no easy means of implementing the committee's recommendation to lower the total number of residencies or control the dramatic numbers of IMGs entering practice in this country (see below), the committee concluded that the connection between patient care and residency training through these mechanisms ought to be severed.

One way to accomplish this is to tie GME support to medical graduates directly rather than to send it solely to hospitals, but the committee did not offer specific advice on how to achieve this objective. A commonly advanced tactic for doing this is through the use of vouchers, at least for the direct medical education portion of GME, conferred specifically on USMGs; additional vouchers might be made available to IMGs who come to the United States solely for training and then return to their countries of origin or otherwise depart the United States. Several knotty questions--for example, the pros and cons of using a voucher system to accomplish these goals--would have to be answered before any program to direct part or all of federal GME support to physicians in training rather than to hospitals (or other settings or institutions) could be implemented. Expanded data collection and research will be needed to provide information on such a significant change in the health care sector.

Controlling IMG Numbers through GME

The committee had strong concerns about the mismatch of physician supply and requirements and about the negative consequences of open-ended immigration of physicians and physicians-to-be from other countries for both the United States and donor nations. Two issues were of paramount interest: the long-term career opportunities for U.S.-schooled physicians and the use of federal tax revenues to underwrite the costs of training foreign physicians here. Changes in general immigration law did not seem to be the best (or even a reasonably feasible) route by which to address these concerns. Rather, the most practical means of creating and enforcing limits on the use of IMGs and federal funds in their training appeared to be through constraints on graduate medical training, which is the final common pathway to practice and employment for physicians.

Training institutions in the United States (and the nation as a whole) have an interest in

continuing to provide graduate training experiences for foreign medical graduates. Such training brings individuals of many cultures and backgrounds together in ways that can have major beneficial effects on international understanding, communication, and cooperation (although the committee notes that the residency training that IMGs now receive here can be inappropriate preparation for the kinds of health care challenges they may face upon returning home). The sticking point for the committee was that such foreign graduates, upon completion of their training here, ought not to remain in the United States to practice, for two main reasons: (1) their skills and professional contributions are doubtless more valuable to their own countries than to this nation, and (2) their presence in the practicing community here aggravates the mismatch between what is a highly qualified domestic physician supply and requirements.

Replacement Funding for IMG-Dependent Hospitals

For purposes of implementing its second recommendation above, the committee believed that payments for GME should be decoupled from those related to the demand for health care services. The committee was very aware, however, that for a small number of hospitals, severe reductions in IMGs in residency slots would constitute a hardship, because those hospitals depend on such trainees for provision of significant amounts of care to the poor, particularly in the nation's inner cities.

The committee believed that policymakers and the professions cannot ignore these service responsibilities. Thus, it urges that new or different *replacement* funding and care delivery mechanisms be found to provide these services to these populations. Therefore, **the committee recommends that the federal and state governments take immediate steps to develop a mechanism for replacement funding for IMG-dependent hospitals that provide substantial amounts of care to the poor and disadvantaged.**

The committee underscores the concept "*replacement* funding," believing that short-term "transition funding" (the idea usually put forward in proposals to deal with the IMG-dependent hospitals that provide major amounts of care to the poor) was not an appropriate idea. In the near future, those hospitals would not likely be able successfully to implement a transition to a more secure financial base while continuing to deliver such high levels of uncompensated care to the uninsured and disadvantaged, inner-city populations. Therefore, committee members preferred a concept of replacement funding for those parts of GME funding that now go to underwrite service delivery, understanding that such subsidies might be needed for a considerable number of years in the present competitive market environment for health care. The committee did not, however, see this as a permanent solution to the problem of serving the needs of poor and disadvantaged populations that may today turn to such institutions for their care.

Several options are available for implementing a replacement funding strategy, although the committee did not explore them in depth. Rather, the committee wished to go on record as favoring limitations in the use of IMGs in graduate training as a means of solving service-delivery problems and, at the same time, as urging policymakers and health professionals to take prompt and responsible steps to ensure that poor and other populations now served chiefly by IMG-dependent hospitals are not harmed. It should be noted, though, that the vast majority of the Nation's hospitals are not dependent on IMGs residents. One significant study found that only 77 of the nearly 6,000 hospitals in the U.S. have substantial residency programs that rely on IMGs and are disproportionately involved in providing care to poor people. In regard to the

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concern with access, however, the committee acknowledged the broader issues of access to health care for all and took note of the view of an earlier IOM committee, which had identified making basic health care coverage universal as a fundamental goal of health care reform.

Enhanced support for the National Health Service Corps is appropriate in order to deal with inadequate distribution of physicians. This program and perhaps others as well will require federal attention if we are to assure access to basic health services for all citizens.

Data Collection and Information Dissemination

The kinds of steps recommended up to this point could have unanticipated consequences for solving the physician supply problem; moreover, the U.S. physician supply is a moving target, and additional steps may be needed. Rather than simply standing aside and assuming that the problems will be solved, the committee judged that a less hands-off approach was appropriate--namely, one that would call for the government and the professions to monitor the situation actively and closely. It also recognized that information gathering and reporting, essentially in a vacuum, would not accomplish the changes and reforms necessary to correct, or prevent, problems of an oversupply of physicians in this country. To reflect these positions, the committee offered a pair of recommendations on data collection and research.

The importance of getting accurate market information to prospective and current medical students was heavily underscored in committee deliberations, especially because of the rising numbers of applications to medical school at a time when a surplus of physicians either exists or at least can be expected in the near future. Young adults ought to be able to plan careers on the basis of reasonably accurate data about employment prospects. Moreover, an efficient, well-functioning market must have good information available to all. The equivocal findings on whether an oversupply of physicians has positive, negative, or neutral effects on costs, quality, access, use of human resources, and academic health centers is evidence enough of the dearth of reliable and valid information on these matters. Hence: **The committee recommends that the Department of Health and Human Services, chiefly through the Health Resources and Services Administration, regularly make information on physician supply and requirements and the status of career opportunities in medicine available to policymakers, educators, professional associations, and the public. The committee further recommends that the American Medical Association, the American Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and other professional associations cooperate with the federal government in widely disseminating such information to students indicating an interest in careers in medicine.** Needed are data on:

- the current size and composition of the physician workforce and future projections of supply and requirements;
- specialty and practice location choices;
- other parts of the workforce, particularly training and employment of personnel that are likely to be substituted for physicians in managed care organizations or hospitals; and
- the complex interactions of physician supply with health care costs, access, and quality.

The committee recognized that the Department of Health and Human Services,

chiefly through its Bureau of Health Professions in the Health Resources and Services Administration, already acquires substantial amounts of such information. In addition, the Council on Graduate Medical Education (COGME) can and does generate topics for data collection, propose workforce policies, and further publicize information generated by the data collection and analysis efforts of federal agencies. So, too, do the major physician associations and specialty societies, including the American Medical Association and the American Osteopathic Association. The committee encourages all these entities to work together in designing or carrying out surveys and other steps in the data collection and analysis enterprise.

The committee calls explicitly for such information to be made widely public in a timely manner--to the professions, to health education institutions, to health care delivery systems and facilities, to university and possibly even high school students (particularly first-year college students), and to the public at large. It fully supports the current efforts of these agencies and organizations and wishes to state its sense that they should continue to be pursued and provided with adequate financial backing, recognizing that different audiences will need different types of reports and information.

These activities lie more in the area of routine, regular data collection, analysis, and reporting. More than that is needed to provide policymakers and the public with an adequate picture of health workforce issues, especially those involving as sensitive and complex a matter as the supply of physicians in the country. Therefore:

The committee recommends that the Department of Health and Human Services provide the resources for research on physician supply and requirements; it specifically recommends that relationships between supply and health care expenditures, access to care, quality of care, specialty and geographic maldistribution, inclusion of women and people of color, and other key elements of the health care system be studied in detail.

Responsibility for these kinds of complex studies would fall within the purview of at least three different federal agencies: the Health Resources and Services Administration (and COGME); the Agency for Health Care Policy and Research, the main source of funding for health services research in this nation; and the Health Care Financing Administration, which oversees the Medicare program (and its GME funding activities) and the federal aspect of the Medicaid program. The nation's major health foundations also can support the types of physician workforce research envisioned above, particularly those with long interest in issues related to the health professions.

This concludes my comments on the 1996 IOM physician workforce report.

Current IOM Study On GME Trust Fund

The IOM is currently conducting a study that will recommend a methodology for teaching hospitals and graduate medical education including allocating funds from a graduate medical education (GME) trust fund. The suggestion for such a study arose from the House Ways and Means Health Subcommittee during my testimony on the physician supply study before that Committee last April. A formal request from Representatives Archer, Thomas, and Johnson was made to President Shine in July with the hope that advice would be available early this year. The trust fund study began in the Autumn and is currently in the Academy's peer review process. The IOM to have the report completed this Spring.

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PHYSICIAN WORKFORCE CONSENSUS STATEMENT

Subsequent to the release of the IOM report, in December 1996, a hearing on physician workforce issues was held in Atlanta to provide individuals and groups an opportunity to respond to a draft multiorganizational consensus statement on this issue. The level of agreement with the draft statement was very high although not unanimous. Following this meeting the American Association of Colleges and Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic Health Centers, Association of American Medical Colleges, and National Medical Association reached agreement and recently released its *Consensus Statement on Physician Workforce*. This document marks the first time six of the nation's leading medical associations have advocated a unified approach to addressing physician workforce issues. The 1996 IOM physician supply study was used in the consensus effort as the starting point or basis for deliberations, and Kenneth T. Shine, MD, President of the IOM, was consulted by the organizations in the early stages and along the way. Thus, there is a marked similarity between the recommendations from these two efforts, although the IOM is not a party to the consensus statement. In addition, the consensus statement goes beyond the report in a number of its recommendations.

The major conclusions presented in the consensus statement include the following. First, there is compelling evidence that the current rate of physician supply (i.e., the number of physicians entering the workforce each year) is excessive. The consequences of physician oversupply are undesirable from the perspective of society at large and the individual physicians who are affected. Second, to decrease the rate of physician supply, which is driven by the number of U.S. and non-U.S. medical school graduates who enter the country's graduate medical education, limits must be placed on the number of medical school graduates entering graduate medical education. Third, it is imperative that the federal government partner with the medical education community to achieve this goal. Furthermore, attention must be given to the implications of GME reforms.

Recommendations

The number of entry level positions in the country's GME system should be aligned more closely with the number of graduates of accredited U.S. medical schools. This realignment should be achieved primarily by limited federal funding of GME positions. The number of funded positions should be sufficient to allow all MD and DO graduates of accredited U.S. medical schools an opportunity to enroll in an accredited GME program.

The U.S. should continue to provide GME opportunities for foreign born physicians who have graduated from non-U.S. medical schools. These physicians should participate in GME under the J-1 Exchange Visitor Program. Their training should not be financed from Medicare funds currently dedicated to support of GME, or from any national payer GME funds that might be established in the future. Moreover, as it is important that these physicians return to their countries of origin after completing GME in this country, the federal government should eliminate all waiver programs that allow these physicians to remain in the U.S. if they agree to accept a practice position in a state or federally designated medically underserved area.

To increase the likelihood that U.S. medical school graduates will establish

practices in underserved communities, **federal funds should be provided to encourage and support medical school efforts to expand opportunities students have to gain experience in rural and inner city communities.** Given that minority physicians have been more likely than non-minority physicians to establish practices in communities with minority populations. Medical schools should be supported and encouraged in their efforts to increase the diversity of their student bodies. To complement medical school efforts to increase the number of their graduates who might establish practices in traditionally underserved communities, **federal incentives should be provided to encourage students to pursue careers as generalist physicians and to establish practices in these communities.**

Changes occurring in the financing of medical care are eroding the individual revenue streams that have supported GME for the last three decades. **A national all payer fund should be established to provide a stable source of funding for the direct costs of GME.** Payments should be made from this fund to entities that incur the costs of GME, whether they be hospital-based or not, or to other entities, such as consortia, that have been designated to receive funds on behalf of the entities incurring costs. In addition, **the formula used currently by the Medicare program to determine captivated payments to managed care organizations should be revised to ensure that the funds intended for the support of GME are used for that purpose.**

Teaching hospitals that lose resident physicians as a direct result of the reduction in the number of entry level positions in the GME system should receive transitional funds to assist them in establishing alternative methods for delivering services that formerly involved resident physicians. That is particularly critical for those institutions that have traditionally used resident physicians to provide services to the medically indigent. Moreover, given the changes in the financing of health care services, **a stable source of funding must be established to support the activities that result in higher costs for teaching hospitals** (i.e., complex nature of patients care for in these institutions, participation of health professions students in the delivery of care, the development and deployment of new diagnostic and therapeutic technologies, and conduct of concurrent research activities).

A national physician workforce advisory body should be established to monitor and periodically assess the adequacy of the size and specialty composition of the physician workforce in the context of the changing needs of the evolving health care delivery system and evolving patterns of professional practice by non-physician health professionals. This body should be legislatively mandated, staffed independently of existing government agencies, and provided a budget that is sufficient to support an appropriate staff to conduct necessary administrative and analytic work. Finally, **the government should continue to provide funds to support research on workforce issues.**

PERSPECTIVES FROM THE AHC

The AHC fully supports the IOM report and the consensus statement and believes that action on their recommendations will be both appropriate and useful. The AHC policy initiatives in the area of physician supply recognize that the end of cross-subsidization of GME is at hand and that dollars spent in the name of graduate education should be for education and the support of salary of learners and teachers. When funding streams for education, service, and

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research are more completely separated, the education dollars should go to the educators and students. Toward that end, AHC believes that the New York Demonstration Project is consistent with the recommendations of the consensus statement and evaluation of this initiative will be quite useful in understanding more fully the complex array of physician workforce issues.

The AHC and others recognize that workforce policy for physicians does not exist in a vacuum, free of consideration for the entire health workforce. In light of this fact, the AHC sees ultimate advantages to an all-payor pool to support education of several relevant professions, particularly those in the clinical settings where interdisciplinary teams are taught and developed. Finally, the most precise modulation of workforce production should be achievable at the regional level. Consortia of educational institutions and organizations providing care could make considerable progress toward establishing and meeting workforce needs within specified regions.

CONCLUDING STATEMENT

At the very least, the United States has an abundance of physicians, and perhaps a surplus. If policies remain unchanged it definitely will, soon, have a surplus. The precise size of that surplus will depend on several unpredictable factors: the extent to which managed care dominates fee-for-service arrangements as the basic organizing and financing structure for the U.S. health care system; technological breakthroughs and the shifting balance between halfway technologies and the definitive interventions that will prevent or cure disease; the changes that may occur in the production of U.S. medical graduates; changes in the financing for graduate medical education; shifts in the rate of immigration and entry into practice of foreign medical graduates; and developments in the use of nonphysician health personnel. The probability of an appreciable surplus of physicians is high enough that some steps need to be taken now to ensure that the nation produces the best physicians it can in appropriate, but not excessive numbers.

As demonstrated by the IOM physician workforce study and consensus statement, the leadership of the health care community has recognized and begun to grapple with the complex issues surrounding a balance physician workforce. The federal government can catalyze the necessary changes in graduated medical education by establishing incentives and adopting policies to separate education and service. It is in the public interest to have very well-trained caring health professionals and the costs involved are high enough that use of public funds to meet these requirements is appropriate. At the same time, our nation needs to deal with geographic maldistribution of health care providers and ensuring care for the poor and disadvantaged. The length of medical education is such that changes in policies will require continuing evaluation and management.

I appreciate the opportunity to present these views to this committee. Finally, the IOM looks forward to bringing the Congress and the Administration the results of its forthcoming report related to a medical education trust fund. Thank you, Mr. Chairman. I would be happy to answer any questions you or Members of the Committee might have.

SUMMARY OF IOM RECOMMENDATIONS

The Institute of Medicine committee recommends that

- no new schools of allopathic or osteopathic medicine be opened, that class sizes in existing schools not be increased, and that public funds not be made available to open new schools or expand class size;
- the federal government reform policies relating to the funding of graduate medical education, with the aim of bringing support for the total number of first-year residency slots much closer to the current number of graduates of U.S. medical schools;
- the federal and state governments take immediate steps to develop a mechanism for replacement funding for IMG-dependent hospitals that provide substantial amounts of care to the poor and disadvantaged;
- the Department of Health and Human Services, chiefly through the Health Resources and Services Administration, regularly make information on physician supply and requirements and the status of career opportunities in medicine available to policymakers, educators, professional associations, and the public; the committee further recommends that the American Medical Association, the Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and other professional associations cooperate with the federal government in widely disseminating such information to students indicating an interest in careers in medicine; and
- the Department of Health and Human Services provide the resources for research on physician supply and requirements and specifically that relationships between supply and health care expenditures, access to care, quality of care, specialty and geographic maldistribution, inclusion of women and people of color, and other key elements of the health care system be studied in detail.

Addendum

COMMITTEE ON THE U.S. PHYSICIAN SUPPLY

DON E. DETMER, *Co-Chair,* Senior Vice President, University of Virginia, Charlottesville
NEAL A. VANSELOW, *Co-Chair*, Professor of Medicine, Tulane University School of Medicine, New Orleans, Louisiana
CAROL A. ASCHENBRENER, Chancellor, University of Nebraska Medical Center, Omaha
HOWARD L. BAILIT, Senior Vice President for Health Services Research, Ætna Health Plans, Hartford, Connecticut
SPENCER FOREMAN, President, Montefiore Medical Center, Bronx, New York
KAY KNIGHT HANLEY, Hanley & Hanley, M.D., P.A., Clearwater, Florida
M. ALFRED HAYNES, Palos Verdes Peninsula, California
ROBERT M. KRUGHOFF, President, Center for the Study of Services, Washington, D.C.
EDWARD B. PERRIN, Professor, Department of Health Services, School of Public Health and Community Medicine, University of Washington, Seattle
UWE E. REINHARDT, James Madison Professor of Political Economy, Princeton University, Princeton, New Jersey
MARY LEE SEIBERT, Associate Provost, Ithaca College, Ithaca, New York
GEORGE F. SHELDON, Professor and Chair, Department of Surgery, University of North Carolina School of Medicine, Chapel Hill

IOM Study Director: KATHLEEN LOHR, then Director of the Division of Health Care Services

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA
FOUNDED IN 1904
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

Testimony of Spencer Foreman, M.D., President
Montefiore Medical Center
On Behalf of the Greater New York Hospital Association

At A Hearing on Graduate Medical Education
Committee on Finance
United States Senate

March 12, 1997

Thank you, Mr. Chairman and members of the Committee for inviting the Greater New York Hospital Association (GNYHA) to testify before you today on graduate medical education (GME). As a New Yorker, I would like to take this opportunity to greet and thank our distinguished Senators, Senator Moynihan and Senator D'Amato, for their leadership on this important issue through the years, and for their critical support of New York's biomedical enterprise.

My name is Dr. Spencer Foreman. I am the President of the Montefiore Medical Center in the Bronx, the university hospital for the Albert Einstein College of Medicine (AECOM) responsible for the training of 350 medical students and 1,200 resident physicians across several hospital and community-based sites. I am a past Chairman of the GNYHA, which represents 175 not-for-profit voluntary and public hospitals and nursing homes in the New York metropolitan area and a current Commissioner of the Prospective Payment Assessment Commission (ProPAC). I have also served on the Committee on the U.S. Physician Supply for the Institute of Medicine and as past Chairman of the Association of American Medical Colleges.

Montefiore is the largest not-for-profit provider of health care and related services to the 1.2 million residents of the Bronx, a community whose socioeconomic and health status indicators rank among the poorest in the United States. Today, Montefiore includes two hospitals that provide more than 47,000 acute care discharges each year; three skilled nursing facilities; one of the nation's largest hospital-based home health agencies; 13 community-based comprehensive primary care centers which provide almost 285,000 ambulatory care visits annually to patients from underserved communities and serve more than 10,000 children in school-based clinics; a 14-site multi-specialty physician group practice that provides about 160,000 annual visits to HMO and fee-for-service patients; and a range of other community-based health services. Through contracts with the City of New York, Montefiore provides physician and other professional services to two public hospitals, North Central Bronx Hospital and Jacobi Medical Center, and health and mental health services at the 16,000 bed Riker's Island Detention Center. With roughly 11,000 employees, Montefiore is the largest private employer in the Bronx.

You have called this hearing today to discuss subjects that are of critical importance to the members of GNYHA. We urge the Committee to: (1) support the enactment of Senator Moynihan's Medical Education Trust Fund Act (S. 21); (2) ensure that teaching and Disproportionate Share Hospitals (DSH) do not bear more than their fair share of reductions in Medicare payments; and (3) correct flaws in current methodologies used to set Medicare managed care payments to HMOs by carving out the GME and DSH components of those rates, paying them according to current Medicare payment rules to the hospitals entitled to receive them, and ensuring that any further adjustments to AAPCC rates be applied in a manner that recognizes differences among regions of the country, such as variations in the cost of living.

NEW YORK MEDICARE GME DEMONSTRATION PROJECT

I would like to begin my testimony by describing a voluntary GME demonstration that will begin in New York State this July. The genesis and concept of the New York Medicare GME Demonstration Project in many respects reflects GNYHA's views in the crucial areas that are the subject of this hearing.

The GME demonstration, which was recently approved and announced by the U.S. Health Care Financing Administration (HCFA), is projected to result in a decrease in New York State of 2,228 residency positions and a simultaneous 13% increase in the proportion of primary care and OB/GYN residents in training over the next five years. It will phase out, rather than immediately eliminate, the Medicare GME reimbursement associated with these resident reductions. This will help ensure that educational and patient care quality, as well as the needs of underserved populations, are not compromised in the transition to a less resident-dependent hospital system.

GME Policy Proposals Have Not Met the Needs of Teaching Hospitals in New York

Past and current proposals to restructure the numbers and types of doctors trained in America have greatly troubled GNYHA. These proposals have focused, among other things, on the elimination of Medicare GME reimbursement for graduates of international medical schools (IMGs);[1] reduction in the prices paid for all residents, but especially those in non-primary care specialties; and the establishment of new Federal regulatory bodies to allocate residency positions around the country. The principal goals behind such proposals have been to achieve Medicare program savings and to address perceived problems in the supply and specialty mix of physicians nationwide.

We have always been guided in our evaluation of proposals such as these by concerns about the effects they would have on our precious biomedical complex, as well as their impact on the patients we serve.

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[1] IMGs are U.S. citizens and persons of foreign citizenship who attend foreign medical schools. Medicare does not currently discriminate in its support of residency programs on the basis of whether the resident is an IMG or a graduate of a U.S. medical college so long as the IMG resident is in a qualified residency program and has passed Parts I and II of the National Board of Medical Examiners test. This test is equally applicable to both American and foreign IMGs.

Our member hospitals serve significant populations of uninsured and low income individuals and families for whom residents are important caregivers. Our evaluations have resulted in deep concern that proposals such as these would wreak havoc on our health care delivery system.

New York's Teaching Hospitals Serve Vulnerable Populations

Teaching hospitals in New York, which include some of the premier academic medical centers in the nation, have training and patient care missions that are inextricably linked. This is shown in the overlap between hospitals receiving both teaching and DSH payments. As you know, Medicare DSH payments are provided to hospitals that serve a large volume of low income Medicare and other patients.[2] Nationally, teaching hospitals receive about 65% of all DSH payments, while 74% of teaching payments go to DSH hospitals.[3] This reflects the important role teaching hospitals play in caring for underserved populations. In New York City, the overlap is even more dramatic; in 1996, an estimated 99% of Medicare DSH payments were paid to teaching hospitals, and 85% of teaching reimbursement was paid to hospitals also receiving DSH. Thus, virtually all teaching hospitals in New York City receive DSH payments, and the majority are classified as so-called "high DSH" hospitals, a reflection of their low income patient shares.

It is not surprising that teaching hospitals in New York City are relied upon to this extent to care for medically underserved populations. In 1995, 21.5% of the City's population, or 1.6 million people, were uninsured and another 26%, or 1.9 million people, were Medicaid beneficiaries.[4] Unfortunately, the number of persons without insurance is growing, not shrinking; from 1994 to 1995, the proportion of uninsured in New York City rose by a rate of 13%, and this trend is continuing.

Indigent patients lack private physicians. Consequently, residents, who "learn by doing" under the close supervision of attending physician faculty, serve as important providers of inpatient and ambulatory care services to such populations. Teaching hospitals, therefore, are at the front line of meeting the health care needs of the 48% of the City's population that lack insurance or are supported by Medicaid.

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[2] The DSH adjustment was developed as a component of the Medicare Prospective Payment System (PPS) because rural and urban hospitals that treat large numbers of low income patients have higher costs than otherwise comparable institutions due to the provision of extra services such as translation and social work, increased security, and other factors such as increased severity of illness. A hospital's eligibility for DSH payment is calculated according to the proportion of inpatient days it provides to Medicaid and low income Medicare beneficiaries. This calculation produces a disproportionate patient percentage for each hospital; hospitals with a percentage of 15% or greater qualify for DSH payments. Hospitals with percentages of 20.2% or higher are considered "high DSH" hospitals.

[3] Medicare and the American Health Care System: Report to the Congress, June 1996, Prospective Payment Assessment Commission) page 63.

[4] U.S. Department of Commerce, Bureau of the Census; NYS Department of Social Services; 1995 Current Population Survey.

Past Proposals and Current Policy

Due to our multiple missions, as well as the poor financial status of our hospitals resulting from years of stringent State regulation of hospital prices, New York's teaching hospitals are particularly vulnerable to cuts in GME and DSH reimbursement. Therefore, we have been adamantly opposed to reductions in these programs.

For example, proposals to eliminate or curtail reimbursement for IMGs would devastate hospitals in underserved urban and rural communities in which IMGs provide essential health care services and draw arbitrary distinctions among residents that are not related to quality, service, or work force goals. IMGs are often concentrated in hospitals located in underserved areas that experience difficulties in recruiting graduates of American medical schools.

The recognition by some that IMGs would have to be replaced by alternative caregivers supported by a degree of funding is an important first step in recognizing the importance of IMGs to underserved communities. However, issues related to the need for permanent funding, personnel recruitment issues in these communities, and the actual impact of withdrawing support for IMGs have not been adequately explored. An IMG cut is too simple a solution for a complex set of problems. As Senator Moynihan has stated many times, residents should be offered positions based upon merit, not country of origin. We thank Senator Moynihan for his longstanding support of this position. We would also like to thank Senator D'Amato for his recent expression of concern to Housing and Urban Development (HUD) Secretary Cuomo over HUD's moratorium on processing J-1 visa waivers.

Other past proposals of concern would have established new residency allocation bodies to assign residency slots to teaching hospitals around the country. This policy would have wrongly relied upon the government to make decisions about the numbers and types of physicians needed in the country. These decisions are best left to educators and health care professionals.

Finally, GNYHA has noted that current Medicare GME payment rules, which eliminate all GME reimbursement for a resident when that resident is cut, create disincentives to reduce the number of residents in training. This is because a hospital loses 100% of the direct and indirect medical education reimbursement associated with the trainee, yet hospital costs do not decrease in like amounts, particularly if the hospital serves uninsured and underserved populations. Physician residents provide valuable patient care services under close faculty supervision while they participate in GME programs. There is a need to continue providing these services with replacement personnel such as full time physicians, nurse practitioners, and others, as well as by making fundamental changes in the way services are delivered, when a resident is cut. The loss of residents coupled with the elimination of funds to supply these services has made it difficult to implement residency reductions.

Because of these concerns, GNYHA's leadership last year decided to try to pursue a more proactive course through development of a GME demonstration to test ways to address the issue of resident downsizing while also meeting the needs of New York's medical centers and our communities. The demonstration project represents an important initiative because it strikes a balance between government intervention, market forces, and local initiative. In particular, it allows hospitals to meet the needs of

their communities while dramatically reducing the size of residency programs and producing permanent Medicare savings.

It should be clearly understood that nothing in the design of this project shields demonstration participants from the effects of Congressional action. The demonstration's parameters specifically provide that any legislative or other changes that apply to other hospitals will apply in full force to demonstration participants for the residents they continue to train.

Need for the Demonstration Project

In each of the past two years, more than half of all U.S. medical school graduates (USMGs) have entered residency programs in the generalist fields of family medicine, internal medicine, or pediatrics. This dynamic has not been lost on teaching hospitals, which have begun to take a hard look at their training programs and consider appropriate ways to downsize and rebalance them. In addition, the cost-cutting pressures of managed care have required hospitals to seek new and more streamlined ways of delivering services.

Recent trends in the number of accredited residency positions nationally shows that growth has slowed and flattened out, likely reflecting these considerations. Thus, while data from the American Medical Association show that the total number of residents in accredited training programs for the past five years increased by 13.7%, from 86,217 in program year 1991-1992 to 98,035 in program year 1995-1996, the last year for which published data are available, the total number increased by only 0.2% from the 1994-1995 to 1995-1996 program year.[5]

However, the challenge in reducing the size of residency programs, particularly at the levels required by the demonstration, is to find a way to pay for the critically important patient care services that would be lost as residency programs shrink or disappear and to make a transition to a delivery system that depends less on residents. Even if some downsizing is occurring on its own in different parts of the country, it is highly doubtful that it would occur at the levels and under the restrictions that will occur under the demonstration. In addition, according to GNYHA staff who helped develop the demonstration and assisted hospitals in evaluating whether or not to participate, many institutions clearly decided to join only because of the special reimbursement features, and others elected not to join because of concerns that the requirements were too stringent or that they could not meet their patient care needs even with the demonstration's special provisions.

Process for Securing Demonstration Approval

Some questions have been raised about the genesis of the demonstration project. It was developed by GNYHA and proposed to HCFA in the summer of 1996. The final terms and conditions developed by HCFA received clearance from the Office of Management and Budget (OMB) in early February, 1997.

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[5] The AMA data may differ from other sources due to their restriction to residents in accredited programs and different data collection techniques.

The time frame used to develop the demonstration was driven by the deadline for submission of available residency positions under the National Resident Match Program (NRMP).[6] Under the NRMP calendar, hospitals were required to submit a list of positions and desired candidates by February 21, 1997 for the class of residents entering in July 1997. A hospital's submission of a match list constitutes a commitment on its part to accept applicants that are "matched" to it through the NRMP. Therefore, February 21, 1997 was the outside date by which to influence the resident class that will enter this July.

Description of Demonstration Features

Participants in the demonstration have agreed to reduce the full-time equivalent (FTE) number of residents by 20% to 25% from the current level over the next five years, as well as to abide by a number of strict terms and conditions. In return, the GME reimbursement associated with these residents will be phased out over six years rather than eliminated immediately as it would be under current Medicare payment policy. The phase-out of this reimbursement provides crucial time and resources to implement new ways of meeting patient service needs formerly met by residents.

Forty two New York State teaching hospitals that train more than two-thirds of the 15,000 residents in New York State will participate in this voluntary demonstration. They include:

- 5 voluntary not-for-profit major academic medical centers, including my own;
- 13 public hospitals, including all of those in the New York City Health and Hospitals Corporation and two county hospitals; and
- 24 voluntary not-for-profit major and community teaching hospitals.

Thus, a full spectrum of teaching hospitals is represented.

Applicability to Medicare managed care. The demonstration is limited to the fee-for-service system and does not affect payments to or from Medicare managed care plans.

Participation Criteria. Hospitals were able to participate in the demonstration individually; jointly with one or more otherwise eligible hospitals; or through an organized GME consortium recognized by New York State. Applicants had to select one of several participation options, and to meet the requirements of the demonstration in five years. Performance will be measured against the 1996-1997 residency program year.

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[6] The NRMP is a national computerized placement process intended to maximize medical student placement in programs of choice. Under the NRMP, all teaching program sponsors, as well as graduating medical students, agree to abide by the rules of the program and to submit rank-ordered lists of preferred programs in the case of students, and preferred students in the case of programs. On so-called "Match Day" (March 19 in 1997), the NRMP matches these lists to place students in residency programs around the country.

The basic participation criteria include reducing the total number of FTE residents by 25% from current levels while maintaining the same ratio of primary care[7] and OB/GYN to total residents. There are two alternatives to the basic criteria. In order to increase primary care training, the demonstration allows participants that increase the proportion of primary care and OB/GYN residents by 20% to reduce the total number of residents by 20%. And, in order to support the development of GME consortia, the demonstration allows a consortium organized and recognized pursuant to state law to reduce the total number of residents by 20% while maintaining the proportion of primary care and OB/GYN training at current levels.

The demonstration encourages collaborative efforts by allowing joint and consortium applicants to meet the participation criteria in the aggregate across all sites. Thus, individual sites within a consortium may reduce by more or less than 20% so long as the consortium in the aggregate cuts 20% of its base year residents. This permits an important level of flexibility to ensure that reductions are not made in an overly rigid way. Eighteen of the 42 participants belong to GME consortia, and another 12 will participate jointly with one or more other hospitals.

Phase-out of GME Reimbursement. The reimbursement associated with cut residents will be phased out over the six years of the demonstration according to the declining percentages shown below.[8] Reimbursement is completely eliminated after six years. Hospitals will use these declining levels of reimbursement, or transition amounts, to meet patient care needs in the absence of residents by hiring replacement personnel, such as full time physicians and other appropriate health professionals, and re-organizing the way that care is delivered to accommodate a smaller resident complement.

Reimbursement Associated with Residency Reductions

Demo Year 1 (1997-1998)	Demo Year 2 (1998-1999)	Demo Year 3 (1999-2000)	Demo Year 4 (2000-2001)	Demo Year 5 (2001-2002)	Demo Year 6 (2002-2003)	Post-Demo Years
100%	95%	85%	70%	50%	25%	0%

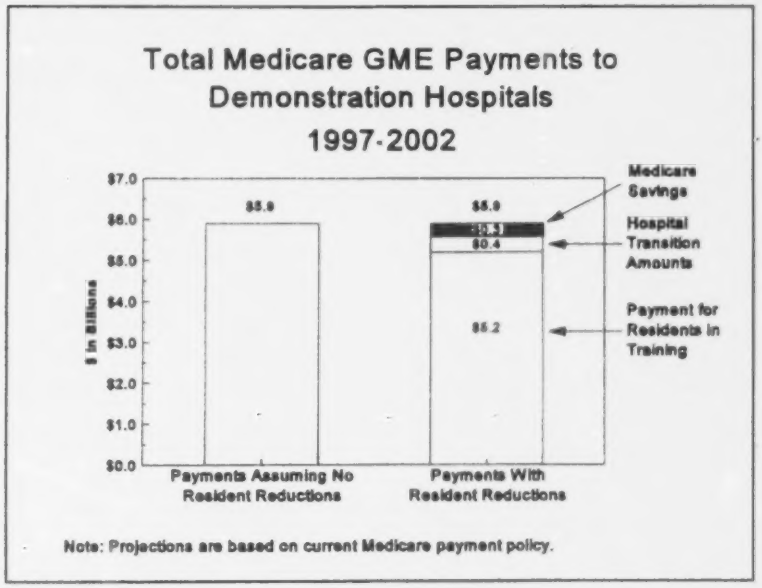
[7] Primary care is defined as under current Medicare law for direct medical education payment purposes, i.e., family medicine, general internal medicine, general pediatrics, general osteopathic medicine, geriatric medicine, and preventive medicine.

[8] The demonstration design includes a second phase to incorporate hospitals able to commence resident reductions in the 1998-1999 program year. Participants that begin in 1998 would be required to make the residency reductions in five years and reimbursement would be phased out over five years under a slightly different schedule. The demonstration thus would end at the same time for both phases.

The phase-out of reimbursement accelerates as the number of cut residency positions grows. That is, a participant will absorb a greater percentage of the loss associated with a larger number of cut residents as the demonstration proceeds.

Penalties for Missed Targets. HCFA will annually measure the performance of each participant to determine if it is in compliance with achievement of the final requirements and interim annual goals. If a participant deviates from the "glide path" that will bring it to the final reduction numbers, it forfeits all transition amounts for that year. If a hospital fails to maintain its reduced resident complement in the sixth year of the demonstration, it will forfeit transition amounts in that year and experience a retroactive halving of the amounts retained in the fifth year. And, if it fails to meet its reduction and specialty mix targets by the end of five years, it will be required to pay back all transition amounts retained since the inception of the demonstration.

Medicare Savings. Medicare will save about $300 million over the life of the demonstration and about $200 million per year after that. Specifically, the loss to hospitals from residency reductions is projected under current payment rules to be about $700 million over six years. As illustrated by the figure below, about 57% of that loss will be retained by the hospital as transition amounts during the six years, while the other 43%, or $300 million, is immediately taken as Medicare savings. After the sixth year, all savings will accrue to the Medicare program.



Other Terms and Conditions. The demonstration imposes three significant caps on participants. First, the operating indirect medical education (IME) intern-and-resident-to-bed ratio (IRB) and capital IME

intern-and-resident-to-average daily census ratio (IRADC) are capped at the 1996 level for all residents in training. In addition, the number of residents in programs sponsored by a participant and rotated to other teaching sites is capped at the current level, preventing participants from increasing rotations elsewhere as they reduce residents at their sites. And, hospitals in GME consortia that are not participating in the demonstration are nonetheless required to cap the number of residents trained at the current level.

International Medical Graduates

The demonstration design very appropriately does not target IMGs for reduction. However, a central evaluation question will likely focus on the practical effects of the project on these residents. Many anticipate that the overall reduction in available positions may well result in lowered proportions of IMGs because American medical school graduates will continue to be more competitive, but for a smaller number of available slots. As IMGs currently fill about half of the positions in New York, there will be ample room for American graduates.

However, the demonstration offers crucial flexibility to hospitals to continue to train IMGs based upon the quality of their candidacies and in underserved areas that continue to experience difficulty recruiting American medical school graduates. This flexibility is essential to ensure that health care services to needy populations are not compromised.

As in the past, GNYHA is absolutely opposed to targeting IMGs for reduction or loss of Medicare support. Drawing a bright line distinction based upon medical school location has a superficial appeal as an easy way to cut GME programs. However, states that rely heavily upon IMGs, such as New York, New Jersey, Nevada, North Dakota, Illinois, Connecticut, Michigan, and others, would be hard hit by such an approach, which would strip their accredited training programs of the support given to identical programs elsewhere in the country. Such an approach would inappropriately deprive communities served by IMG residents of the services of fine and fully qualified American and foreign physicians.

The concern that IMGs contribute to a physician oversupply results in large part from the pressures that managed care is placing on all health care providers. Whether a mild physician oversupply is harmful is the subject of different perspectives on which I offer no opinion. I will note that at Montefiore, we have witnessed a changing physician environment that has benefited the communities we serve. We have been aggressively pursuing the development of ambulatory capacity in both low income and middle class neighborhoods, and are grateful to find that physician recruitment has become easier as it appears that physicians are exploring a wider array of options than they had in the past.

IMGs are not the sole cause of or solution to the problems that have been raised, and we urge that you not support proposals to withdraw Medicare's support for their training.

Process for Making Resident Reductions

We believe that the demonstration combines important elements of market forces with responsible government intervention. While the project imposes clear parameters for residency reduction and

primary care/OBGYN training, teaching hospitals and their faculty will be free to make their own decisions about how best to meet these criteria and adjust their academic mission to a market being reshaped by managed care. If done properly, it should preserve programs that train physicians in specialties for which the long term need is high and downsize those for which it is not.

Participants have established new internal processes to make these decisions, which will likely evaluate a combination of factors such as the quality of programs, job placement experience of recent graduates, service needs within the hospital, the availability and cost of strategies to replace or re-organize services to accommodate the loss of residents, and other variables. The crucial phase-out of GME reimbursement will allow participants to make these decisions as part of a transition to a different type of hospital system.

The demonstration is not perfect in every respect. Some might find its requirements somewhat rigid and difficult to meet, and others might worry about meeting future patient care needs. However, from our perspective, the demonstration represents a real opportunity to explore ways to respond to national concerns about physician supply and achieve Medicare savings while we also adjust our own activities and structures to adapt to a changing health care system, maximize the quality of patient care and training, and ensure that the needs of our local communities continue to be met.

CRITICAL NEED FOR A NATIONAL GME TRUST FUND

GNYHA strongly supports Senator Daniel Patrick Moynihan's "Medical Education Trust Fund Act of 1997" (S. 21) and urges Congress to include Senator Moynihan's bill in its FY 1998 budget proposals. Congresswoman Nita Lowey recently introduced the companion bill in the House (HR 881).

A Trust Fund is essential to ensure that the responsibility for paying for the training of our nation's future doctors is shared by all payers. The Trust Fund should be funded at levels adequate to ensure that we can maintain our preeminent training system, and all payers should pay their proportionate share. While the details of how the Trust Fund would be operated need to be worked out, and under the Moynihan bill would be determined by a new advisory commission which we strongly support, we do believe funds should continue to flow directly to the institutions that incur the costs of training according to current Medicare payment rules. In addition, we would suggest that you consider fashioning payment rules that would avoid imposing harsh financial losses for reducing the numbers of residents trained. This could facilitate a process for downsizing and rebalancing GME programs where it makes sense.

I would also like to emphasize the need for both a carve out of GME from rates paid to Medicare managed care plans, discussed below, and creation of a Trust Fund. The carve-out is needed to maintain Medicare's effort and the Trust Fund is needed to ensure that non-Medicare payers contribute. The proposals, therefore, are not the same and instead are distinct and necessary components of the support needed for GME. The Moynihan bill, of course, contains both of these important proposals.

You may be aware that through historic legislation passed last summer, New York State established a Statewide GME pool to which private payers contribute about half of the costs of GME attributable to the private pay population. The existence of this pool does not in any way diminish our enthusiasm for

a national solution, however, because the mechanisms that must be relied upon at the State level to implement such pools are extremely complex. This is because States do not have the flexibility of the Federal government to develop simple funding mechanisms, and instead must negotiate a thicket of complicated Federal ERISA, provider tax, and State insurance law requirements in the design of such pools. We have nothing but admiration and praise for our Governor and State Legislature for meeting these challenges, but believe that a Federal solution would greatly simplify the structure and administration of such a GME fund.

MEDICARE DSH AND GME PAYMENTS

Congress Should Not Impose More Than A Fair Share of Reductions On Teaching and DSH Hospitals

While we share the national concern over the solvency of the Medicare Part A Trust Fund, we urge that the Committee not impose more than a fair share of any Medicare payment reductions on teaching hospitals, and especially on teaching hospitals that also receive DSH payments. This would be the result if three payment areas were targeted: the annual inflation adjustment, or update factor, to all Prospective Payment System (PPS) rates; the indirect medical education factor and direct medical education payment; and DSH payments. If Congress were to seek Medicare savings in these areas, it would impose a multiple blow to all teaching hospitals with even greater harm inflicted on teaching hospitals that also rely upon DSH payments.

This is because the IME and DSH add-ons in particular are calculated upon the base of PPS rates. Reducing PPS payments through reductions in the update factor would ripple through to reduce projected IME and DSH payments. Separately reducing IME and DSH payments would impose real cuts, not reductions in the rate of growth, on a class of hospitals that continues to be least able to withstand them.

Of course, through the GME Demonstration Project, New York's hospitals will produce significant permanent savings to the Medicare program through reductions in the GME reimbursement associated with cut residency positions. Despite these savings, demonstration participants are not in any way protected from further payment policy changes made for teaching hospitals everywhere. We urge you to limit further reductions as you continue your deliberations.

Disproportionate Share Hospital Payments

Although DSH is not technically the subject of this hearing, the interplay noted earlier between teaching hospitals and DSH hospitals makes the subject impossible to ignore when discussing Medicare reimbursement policy. As noted earlier, virtually all of GNYHA's member hospitals are eligible for payments under the DSH program, and most of them, including Montefiore, qualify as "high DSH" hospitals. The program is an essential component of our ability to maintain the quality of care to Medicare beneficiaries and meet the needs of low income patients. Particularly given the increasing incidence of the loss of insurance and uncertainty regarding the impact of welfare reform, we urge Congress to support proposals that would maintain DSH at current levels and allow it to vary to accommodate changing needs.

The DSH adjustment compensates hospitals for the limitations of the Medicare PPS case-mix adjustment with respect to recognition of the higher clinical and non-clinical costs associated with caring for poor Medicare patients. Because hospitals that care for a high proportion of low income patients tend to bear disproportionate financial burdens, the DSH adjustment is necessary to ensure their continued access to quality care. The current proxy that Medicare uses for measuring indigence is the sum of two ratios: the ratio of Medicare SSI to total Medicare inpatient days and the ratio of Medicaid to total inpatient days.

Our principal concern regarding the current DSH proxy is the growing inability of hospitals to identify Medicare- and Medicaid-sponsored patients enrolled in managed care plans, which is caused because insurance identification cards denote the patient's health care plan, but not the sponsor. Thus, we strongly endorse a proposal by ProPAC to require a sponsorship code in each patient's insurance identification number. While states have the authority to mandate such a change, a Federal requirement is far preferable to ensure national compliance.

This Committee included an amendment sponsored by Senator D'Amato in the Balanced Budget Act which would have accomplished much the same thing. We thank Senator D'Amato and the Committee for your attention to this issue in the past and urge your support once again. We also note that the President's proposed budget would freeze each hospital's disproportionate patient percentage factor, which is used to calculate DSH payments, for two years while new approaches to identifying low income patient populations are identified, an approach we endorse.

In its March 1997 report, ProPAC also recommends modifying the DSH proxy by incorporating recipients of other government subsidies as well as the uninsured and underinsured. While this approach seems sound, we believe that any new measures should be thoroughly researched and the effects on providers evaluated before changes are enacted. There is sufficient need to measure services provided to the other populations to warrant permanent, additional data collection even if a change in the DSH proxy is not ultimately recommended.

In addition, ProPAC recommends measuring indigence through inpatient and outpatient charges rather than through inpatient days. Since both are a proxy for cost, we would urge that new research center on cost rather than charges. Cost can be estimated through application of the ratio of cost to charges. This extra step is value added because there is considerable variability in the mark up of cost to charges around the country. We endorse the inclusion of outpatient costs in the research.

Finally, given that hospitals rely greatly on the current DSH adjustment, we urge that any future changes in payment policy that reallocate funding be phased in appropriately to give providers sufficient time to adjust their programs.

ENSURING CONTINUED SUPPORT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS IN MEDICARE MANAGED CARE

Need For AAPCC Carve Out

GNYHA believes that the benefits of managed care experienced by commercial populations should be increasingly available to Medicare beneficiaries, but urges that this be done in a way that preserves Medicare's commitment to high quality training and research and services to underserved populations.

As you know, health maintenance organizations (HMOs) receive monthly payments for each Medicare beneficiary enrolled in their plan; such payment is called the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is calculated under a formula that includes Medicare payments for GME and DSH in the rates paid to Medicare contractors. However, HMOs are not required to pass these public benefits payments on to the hospitals that provide the services and incur the costs, or even to contract with them. Medicare managed care enrollment is increasing at a rapid pace in the New York City area, growing by almost 30% in the past year. It is essential that the transfer of GME and DSH payments to HMOs be stopped, not only to sustain the important activities supported by these special payments, but also to ensure that teaching hospitals, upon whom the Medicare population relies, are able to serve as an important component of the infrastructure to expand Medicare managed care.

We therefore urge Congress to enact provisions to carve out 100% of GME and DSH payments from the AAPCC and pay them to hospitals that provide these services according to current payment rules. As mentioned earlier, such a provision is included in Senator Moynihan's Medical Education Trust Fund Act (S. 21). This Committee approved a carve-out as part of its version of the Balanced Budget Act. The President has included a carve-out in his budget proposal. Surely, with so much bipartisan support, the time has come to enact this important provision.

Finally, to the extent that further adjustments are made to the managed care rate paid to HMOs, we urge that regional variations in cost of living and similar factors be recognized. Not all hospitals are alike, and not all regions of the country are alike. If we are to preserve the best in our system, we need to recognize those differences in the way we pay for Medicare managed care.

Mr. Chairman and members of the Committee, thank you very much for the opportunity to testify today. I would be pleased to answer any questions you may have.

THE NEW YORK TIMES, FRIDAY, FEBRUARY 28, 1997

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Fewer Doctors, Lower Medicare Costs

Hospital officials outside New York are reacting with jealousy, even rage, to the Clinton Administration's plan to pay New York hospitals hundreds of millions of dollars to train *fewer* physicians over the next six years. But the anger is misplaced. The plan is an innovative way to bring Medicare costs under control and, in the process, better match the nation's supply of physicians with patient needs. Rather than griping that they have been left out, teaching hospitals in Boston, Los Angeles and other training centers ought to root for New York's success in the hope that what is good for New York will soon become policy everywhere else.

The goal of this demonstration project is to help reduce a national surfeit of urologists, anesthesiologists and other specialists. Hospitals have been slow to stop training young doctors, called residents, in such specialties because Medicare takes away up to $100,000 for every residency they cut out of their teaching programs. The medical community has blocked previous attempts to cut down on Federal teaching subsidies, in part because residents bear the brunt of treating uninsured, often indigent patients in many urban neighborhoods.

The prospects for success in the New York demonstration are enhanced by the fact that its provisions were proposed by the hospitals themselves. Under the plan, teaching hospitals that voluntarily cut training slots by about 20 percent — perhaps 2,000 positions statewide — will be allowed to keep over the next six years about 60 percent of the Medicare subsidies for the positions that are eliminated. That will provide extra money with which to restructure patient care to accommodate the loss of residents. Washington also comes out ahead because it will reap partial savings, worth hundreds of millions of dollars, over the first six years and full savings by the seventh year.

Some critics charge that Bruce Vladeck, a New Yorker who heads the agency that oversees Medicare, put together a sweetheart deal. But budget officials also approved the plan. New York is a proper test site because its hospitals train 15 percent of the nation's residents and treat many uninsured patients. If the project cannot succeed in New York, it cannot serve as a worthy national model.

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Senator James M. Jeffords
Opening Statement
Hearing of the
Committee on Finance
on
Graduate Medical Education
March 12, 1997

* * *

Thank you, Mr. Chairman. I'm especially pleased that you have scheduled this hearing so that we can learn more about the President's 1998 budget proposal for the financing of graduate medical education through Medicare and the recently publicized New York Teaching Hospitals' Graduate Medical Education Demonstration Project.

Dr. Vladeck, and our other witnesses, I want to welcome you and thank you for coming to the committee and sharing your suggestions on best approaches for keeping the Medicare Program an appropriate vehicle for financing the clinical education of our health professionals, who provide needed services to our disabled and elderly.

I'd like to take this opportunity to mention a few issues facing the Finance Committee that I believe will need close attention and are of particular concern to me:

1. The needs of academic medical centers in rural areas; and

2. The demand to take a more expansive approach to Medicare reimbursement for resident services to enable payment for residents placed outside the traditional hospital environment, since much of the health care provided today is delivered in clinics and in other ambulatory settings.

I applaud the Administration for its attempt through tne New York Demonstration Project to take an innovative, budget neutral approach to solving the potential problem of physician oversupply through reducing residency slots. I would like to see more of these demonstrations to explore innovative approaches to determine how to best address the physician workforce issues needs to meet the demands of our rural communities in these changing time for health care delivery.

I want to take this opportunity to thank our witnesses for the work they have done to assist the Congress in its decision making process. We realize that the current health care environment is causing concern and uncertainty for the teaching hospitals and recognize that these hospitals have a vital stake in providing an arena where education, service, and research can flourish. My wish is that we can take a long look at the complexities and inequities involved in the financing system so that we can make decisions based on what is good for all Americans in all geographic areas of the nation.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW, WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125
Jordan J. Cohen, M.D., President

on

FUTURE FINANCING OF GRADUATE MEDICAL EDUCATION

before the
Senate Committee on Finance

Presented by
Ralph W. Muller
President
University of Chicago Hospitals and Health System
and
Chair-Elect
Council of Teaching Hospitals and Health Systems
Association of American Medical Colleges

March 12, 1997

Mr. Chairman, and distinguished members of the Committee, I am Ralph W. Muller, President of the University of Chicago Hospitals and Health System. I also am Chairman-Elect of the AAMC's Council of Teaching Hospitals and Health Systems (COTH). The AAMC welcomes the opportunity to testify on the future financing of graduate medical education (GME). The Association represents all of the nation's 125 accredited medical schools, approximately 400 major teaching hospitals, including 75 Veterans Affairs medical centers, the faculty of these institutions through 89 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents.

I come before the Committee today to express the Association's concern about the future financing of the special missions of teaching hospitals and medical schools in a fiercely price competitive environment. I will offer possible financing approaches so that these institutions, which constitute the backbone of the American health care system, can continue to meet their societal responsibilities. I also will address the role of Medicare in financing GME and its related costs under the fee-for-service and managed care portions of the program.

The AAMC understands the difficulty Congress faces in reducing the rate of growth in the Medicare program to extend the solvency of the Part A Trust Fund. The Administration's proposed reductions for Medicare and Medicaid would have a significant impact on the health care system. Moreover, the changes contemplated would have especially profound effects on the nation's teaching hospitals and medical schools. Teaching hospitals play a special role in society.[1] They serve large numbers of the poor and the elderly and depend heavily on Medicare payments for direct graduate medical education (DGME), indirect medical education (IME), and disproportionate share (DSH). Many teaching hospitals also serve large segments of the Medicaid population. In 1995, Medicare and Medicaid payments constituted one-half of all patient revenue for the average COTH member.

Before addressing specific proposals, however, I would like to comment on recent reports of near record prospective payment system (PPS) inpatient margins among teaching hospitals. New data on hospital financial performance show that the average teaching hospital, like all other hospitals, has improved its financial position relative to Medicare PPS and all other patients. At its January meeting the Prospective Payment Assessment Commission (ProPAC) presented PPS inpatient and total margins. The average PPS inpatient margin for major teaching hospitals increased to 18.6 percent in 1995, while their average *total* margin was 3.7 percent. The general trend for most hospital groups shows increasing PPS and total margins, but these 1995 data are preliminary and subject to change. Only 60 percent of hospitals had reported data, and large teaching hospitals and those with late-year Medicare Cost Report closings were under-represented in the sample. Additionally, the aggregate margins are "average" financial indicators and mask the wide variation among teaching and all other hospitals' performance.

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[1]See Appendix A for a detailed discussion of the roles and characteristics of teaching hospitals.

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Dramatic declines in hospital costs are driving improvements in margins. Teaching hospitals have made great strides in increasing labor productivity and reducing length of stay. They are successfully adapting to a rapidly changing environment. For all hospitals, payments per discharge have increased steadily, while costs per discharge have been decreasing since 1993-94. For major teaching hospitals, the annual change in Medicare costs per discharge during the period 1993-96, after adjusting for inflation, was minus 3.3 percent, the same percentage as was true for non-teaching hospitals. Whether hospitals can achieve these striking results over the long-term without diminishing quality and access to health care is doubtful. Even after reducing their costs at the same impressive rate as non-teaching hospitals, teaching hospitals are still at a disadvantage when competing on price due to their added roles in the delivery system.

Gains in operating efficiency notwithstanding, the AAMC notes that the payment policies adopted by Congress have been a resounding success in assuring the vitality of these institutions. Over the past several years, Congress has pursued a deliberate course of acknowledging the broader mission and overall financial viability of teaching hospitals, as measured by equity in total margins across hospital groups, to assure access and quality of care for Medicare beneficiaries and other patients. Major teaching hospitals depend heavily on IME and DSH payments; they receive two-thirds of all DSH payments. In FY 1996, one-third of teaching hospitals' PPS payments came from the IME and DSH payment adjustments because they so often care for severely ill patients who require specialized services and large numbers of low-income poor. Some policy makers have pointed to a high average PPS inpatient margin as reason for decreasing Medicare payments to teaching hospitals, specifically the level of the IME and DSH payment adjustments. While these mission payments have contributed to their higher average PPS inpatient margins compared to non-teaching hospitals, the total margins of major teaching hospitals remain consistently lower than those of any other hospital group.

Other factors, such as teaching hospitals' overall Medicare activity and the ability to cost shift, should be considered in measuring financial viability. Teaching hospitals have negative margins on average when all Medicare-related payments and costs are compared. According to ProPAC's June 1996 report, major teaching hospitals experienced losses in 1994 from treating Medicare patients when all inpatient and outpatient costs were considered. Teaching hospitals also registered higher losses from uncompensated care and had less ability to cost shift compared to other hospitals, which led to lower total margins. Public major teaching hospitals cared for few privately insured patients who generally pay higher rates. Private major teaching hospitals were able to attract privately insured patients, but made pricing concessions to maintain their patient volume. Their private payer payments were not nearly as much above costs as other types of hospitals.

Why Teaching Hospitals and Medical Schools Are Worried About the Future

Teaching hospitals and medical schools are apprehensive about their ability to maintain their missions. Providing an environment in which health professional education, clinical research and innovation can flourish adds to the cost of patient care services at teaching hospitals and medical schools. Both entities have traditionally relied on a complex and delicate web of

support from clinical revenue to finance their additional missions.

The Current Financing of Teaching Hospitals. Teaching hospitals have long depended on revenues from patient care to cover most of the costs of the many services they provide for society. Patient care dollars enable teaching hospitals to support specialized services that are particularly expensive but vital community and regional resources. Patient care revenues also help cover the costs of treating those who cannot pay for their care, training health professionals, and providing an environment for research.

Teaching hospitals are experiencing increasing difficulty in maintaining their educational and other social missions, which add to their cost structures, because they must meet the price competition from nonteaching hospitals when negotiating with nongovernment managed care contractors. Private insurance companies, businesses, and some government purchasers of health care want to pay the lowest possible price for only those services that their enrollees receive. In addition, state Medicaid programs are increasingly entering into risk-based contracts under which teaching hospitals must compete with nonteaching hospitals.

At present, only two purchasers of services--Medicare and, in many states, Medicaid--specifically recognize the additional costs of teaching hospitals. Since the focus of this hearing is the Medicare program, I will not address Medicaid's participation in GME financing, except to note that most state Medicaid programs, but by no means all, include payments under their fee-for-service systems for the equivalents of Medicare DGME and IME payments. Under Medicaid managed care, however, these payments often are not made to teaching hospitals. The AAMC is concerned that state Medicaid programs are retreating from making special payments to teaching hospitals for their education and other societal missions.

The Current Financing of Medical Schools. Medical schools play a pivotal role in anchoring academic medical centers and producing the public goods of education, research and clinical innovation. The schools educate our future physicians and biomedical research scientists, conduct 50 percent of the total extramural research supported by the National Institutes of Health (NIH), and provide the faculty physicians who staff teaching hospitals, direct the residency programs, generate clinical discoveries, and provide outstanding medical care to a disproportionate share of the nation's indigent and uninsured. Although the schools appear to be robust enterprises, their financial structures are fragile, and their financial stability is highly dependent on clinical revenues.

Medical schools support their education and research activities from diverse sources of income, but on average, only 10-20 percent of that income is derived from secure sources such as tuition and fees, endowment earnings and gifts, or (mainly for the public schools) state support. About 20 percent of their income comes from the NIH and 10 percent comes from a variety of other sources. Nearly 35 percent comes from fees generated by the faculty's practice of medicine, and about 15 percent is from direct payments from teaching hospital partners. In other words, nearly 50 percent of the schools' aggregate annual revenue is derived from the practice of medicine, and the surpluses generated from these revenues have been a vital source of flexible funds for

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new academic investments.

Revenue comes into the medical school with varying degrees of restriction in use (mild to extreme) and must be maintained in discrete accounts that may be accessed only for designated, specific purposes and not commingled. Grants and contracts provide the clearest example of highly restricted revenues. Research grants and contracts are awarded for the express purpose of supporting the proposed research. Gifts to medical schools are characteristically restricted, sometimes to a broad area of application, but more often to work on specific diseases or to support the scholarship of specific faculty.

The financial health and stability of medical schools are best reflected, however, in the discretionary revenues and unrestricted fund balances that traditionally have been available to schools and departments for support of core academic objectives, for which designated, or restricted, funds are either insufficient or non-existent. Such core purposes would include support of faculty salaries, stimulation of new academic programs in education and research, investment in equipment and facilities, initiating new research programs, and providing the substantial funds required for cost-sharing on sponsored research. Discretionary revenues are also called upon to support new educational initiatives and curriculum changes, for example, those required to provide medical students with expanded clinical training in ambulatory and community sites.

Tuition and fees and state and local appropriations are ostensibly major sources of unrestricted funds. However, tuition and fees are relatively modest, accounting for only 4 percent of total medical school revenues in 1995. Although state and local appropriations may be quite substantial, much of this revenue is committed to existing needs, often for support of tenured faculty.

Facilities and administrative cost recovery on research grants and clinical revenues, primarily from faculty practice plans, are both important sources of medical school discretionary revenues. A portion of clinical revenues is converted to unrestricted funds through the excess that remains after all of the direct and indirect costs of the clinical practice have been met, including the costs of uncompensated care.

Faculty practice plan revenues support academic programs in several ways. First, some revenue is directly transferred to the medical school, its departments, and other research institutes and centers. This is discretionary money available to deans and department chairs to underwrite important teaching programs and a range of scholarly and research activities. An AAMC study estimated that in 1992-93, a total of $2.4 billion, or 28 percent, of faculty practice revenue, was used to support clinical research, scholarship and teaching programs. Second, the revenues are used to compensate clinical faculty for time spent in teaching and research. If clinical faculty were not engaged in these academic activities, their clinical productivity and the generation of patient care revenue would be far higher. Finally, some faculty practice plan revenues provide direct support for residents and fellows, and indirect support for academic programs by paying the operating expenses of clinical practices in which these programs are intermingled. However,

research also is supported by a variety of public, private, and institutional sources, including faculty practice plan revenue.

The federal government, especially the NIH, has been and remains the cornerstone of research support at medical schools and teaching hospitals. Institutional cost-sharing has been a growing factor in federally-sponsored research, and research sponsored by philanthropic and industrial sources rarely pays the full costs borne by the institution. The shortfalls caused by uncompensated research costs are offset significantly by funds from clinical practice income. These funds also provide seed money for innovative faculty research projects prior to demonstration of their competitiveness for external funding, support for investigators during temporary periods in which funding is not available, information technology, renovation of research facilities, major research equipment, faculty recruitment, administrative compliance with state and federal regulations, and assorted overhead expenses not reimbursed through other mechanisms.

Medical schools are concerned about meeting their responsibilities of education and research in a changing competitive health care system. Purchasers of health care services show a reluctance to share responsibility for the added costs associated with teaching and research. The impact of these changes is being felt particularly by medical schools in areas of high managed care penetration, where revenues generated per faculty member and faculty practice margins have been declining since 1991. As managed care penetration accelerates and price competition intensifies, the impact on medical schools will become more generalized, and the unique and delicate financing structure of medical schools will unravel. The ability of medical schools to sustain their academic missions is increasingly at risk.

A Shared Responsibility Approach

As complex institutions with multiple and varied funding streams, medical schools and teaching hospitals are subject to many different environmental pressures, but their dependence on clinical revenue makes them extremely vulnerable to changes in the delivery system. Teaching hospitals and clinical faculty are adapting to a market-driven health care system, but no matter how successful they are at reducing their costs and managing efficiently, they will always be at a competitive disadvantage because of their additional responsibilities of education, research and specialized patient care.

The AAMC believes that a "shared responsibility" approach to financing the special missions of teaching hospitals and medical schools is necessary to assure the future of American medicine. The AAMC has consistently supported a policy that graduate medical education and other societal missions are the shared responsibility of all entities that pay for hospital and health-related services on behalf of their enrollees. Two Congressional advisory bodies agree. ProPAC, in its March 1997 report to the Congress, recommends that explicit payments for GME and teaching hospital costs should not be limited to the Medicare program. The Physician Payment Review Commission (PPRC) has called for the participation of all purchasers of health care services in financing the costs of GME. The federal Council on

Graduate Medical Education (COGME) has recommended all-payer funding as well.

Two innovative approaches to funding the costs of medical education emerged in the 104th Congress. Both would have established a trust fund from which payments could be made to support the special costs associated with the education mission. The AAMC endorses the concept of a trust fund as a means of assisting teaching hospitals and medical schools in meeting their mission-related costs.

One approach to a trust fund was taken in the Medical Education Trust Fund Act of 1996 (S. 1870) by Senator Daniel Patrick Moynihan (D-NY). Senator Moynihan has again introduced the bill, the Medical Education Trust Fund Act of 1997 (S. 21) in the 105th Congress. The bill would establish a trust fund for graduate and undergraduate medical education and provide three sources of funding: an assessment on private sector health insurance premiums, Medicare, and Medicaid. Five accounts would be established, including accounts for teaching hospitals and one for medical schools. The AAMC is gratified that the conceptual framework of this legislation is in substantial accord with our policies. To our knowledge, this is the only bill that would provide funds for medical schools to partially offset their loss of revenue from clinical practice in a competitive environment. Companion legislation (H.R. 881) was introduced in the House of Representatives on February 27, 1997 by Representatives Nita Lowey (D-NY) and Louise Slaughter (D-NY).

The trust fund concept also was included in H.R. 2491, the Balanced Budget Act of 1995, as adopted by the U.S. House of Representatives on October 19, 1995 and by the U.S. Senate on October 28, 1995. This legislation would have created a Teaching Hospital and Graduate Medical Education (THGME) Trust Fund consisting of five separate and distinct accounts. Three of the five accounts would have been funded by appropriated general revenue, and the Medicare program would have contributed funds to the two other accounts. Payments would have been made to teaching hospitals or qualified graduate medical education consortia.

The AAMC strongly supports the creation of a trust fund for medical schools and teaching hospitals. Shared responsibility for clinical education is an essential ingredient in a competitive delivery environment. Purchasers of health care services are now largely unwilling to pay a premium for education and research. Competitive pressures preclude them from doing so. The federal government alone is in a position to make formal and explicit what has always been informal and implicit by facilitating financial support for medical school academic programs and teaching hospitals through contributions to a trust fund. In so doing, it assumes an appropriate and necessary role: to ensure that all beneficiaries of the public goods created by medical schools, their faculties, and teaching hospitals continue to participate in their support.

A trust fund would provide a framework for all segments of the health care delivery system and society to share in the financing of clinical education. Once a financing mechanism is created, several difficult design issues must be addressed. One pivotal issue is how to finance the trust fund. Financing could be provided by general revenues, as proposed in the Balanced Budget Act of 1995, or through an assessment, or tax, on purchasers of health care services, as in the

Medical Education Trust Fund Act of 1997.

The Balanced Budget Act of 1995 devised a novel approach to assist teaching hospitals in meeting the special costs associated with their education mission. The Association endorses the trust fund concept, but recognizes that there are at least two different rationales for the creation of the trust fund. One rationale is that the trust fund serves as replacement funding to ameliorate the impact of reductions in Medicare DGME and IME payments. However, the AAMC hopes that, to a significant degree, the creation of a trust fund, which includes non-Medicare revenue, could be viewed as a transition toward establishing a fund based on shared responsibility. Designated general revenue funds could be viewed as replacing dollars that Medicaid programs have contributed and that private payers traditionally have provided through higher payments to teaching hospitals.

Another important design issue is the structure of the payment mechanism. The AAMC supports retaining the structure and methodology of the current Medicare payment system for GME, namely the continued formula-driven contributions of separate DGME and IME payments. The AAMC has long held that these two payments with an education label serve separate and distinct purposes and should continue to be paid as individual contributions to a trust fund. The AAMC also believes that the funds should be distributed using a methodology that is related to teaching intensity and to the complexity of the patient, not to payer status. If payments are made based on Medicare utilization, for example, some institutions may not receive adequate funding for their involvement in education. We understand that new methodologies for distributing funds are being studied by the Institute of Medicine (IOM). The AAMC is eager to work with the members of this Committee to enact a trust fund for medical schools and teaching hospitals.

I would now like to focus the rest of this testimony on the Administration's specific Medicare budget proposals for FY 1998. The President has made proposals in both the managed care and fee-for-service portions of the program that would have a profound impact on teaching hospitals and teaching physicians. They include eliminating the mission-related payments from the calculation of the Adjusted Average Per Capita Cost (AAPCC), reducing the IME adjustment, changing rules for making DGME and IME payments, and creating incentives to control high-volume inpatient physician services.

Eliminating IME, DGME and DSH Payments from Medicare Managed Care Rates

As Medicare beneficiaries transfer from fee-for-service to capitated arrangements, teaching hospitals and DSH hospitals (often one and the same) are being placed at an ever greater competitive disadvantage in the marketplace. The reason for this is a direct consequence of the manner in which Medicare calculates the rate it pays to risk contracting plans for each enrolled Medicare beneficiary. This rate, called the Adjusted Average Per Capita Cost (AAPCC), is based on aggregate Medicare fee-for-service expenditures in a given county, including program spending for IME, DGME and DSH payments to hospitals. As a result, payments intended by Congress to support the societal missions of GME and indigent care are going instead to managed care organizations who refuse to pass the payments on to teaching and DSH hospitals.

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At the same time, the expenses that these payments are designed to offset remain on the teaching and DSH hospitals' books and render them more costly than their competitors.

The AAMC strongly supports proposals to exclude IME, DGME and DSH payments from the AAPCC rates and pay these mission-related dollars directly to teaching and DSH hospitals whenever they provide care to Medicare beneficiaries who are enrolled in risk-based plans. The Medicare program should contribute to the mission-related activities of teaching and DSH hospitals on behalf of its beneficiaries in the traditional fee-for-service program and in risk-based plans. As the historical centerpiece of GME financing, Medicare sets the standard for participation.

The Administration's proposal would not adversely affect the savings needed to extend the solvency of the Medicare Part A Trust Fund. The Administration, in its FY 1998 budget, proposes to eliminate the three mission-related payments from the calculation of the AAPCC rates. This proposal would result in a shift of current program expenditures, reducing payments to Medicare HMOs and increasing payments to teaching and DSH hospitals. The carved-out payments would be transferred to a funding pool and then paid directly to teaching and DSH hospitals or to managed care plans that operate residency programs when they provide services to risk plan enrollees. A carve-out also is featured in bills introduced by Senator Judd Gregg (R-NH) and Representative Ken Bentsen (D-TX) and in The Coalition's Common Sense Balanced Budget for FY 1998.

Removing IME, DGME and DSH payments from the calculation of the AAPCC rates would partially reduce geographic variation in the rates. For technical reasons, a number of groups, ranging from ProPAC and PPRC to COGME to the American Academy of Actuaries, have called for modifying the AAPCC methodology. The methodology has come under heavy criticism because it results in rates that vary widely among counties. One reason for the geographic variation is the inclusion of the special teaching-related and DSH payments in the rates. Recently the American Academy of Actuaries noted that removing the special payments would improve the HMO formula by reflecting more closely the actual costs of providing care to risk enrollees.

In addition to the technical aspect of reducing variation, both ProPAC and PPRC have recommended removing the special payments from the rates and paying them directly to teaching and DSH hospitals to achieve the policy objectives of the Medicare program. They have questioned whether all risk plans should receive the special payments in their rates, since the funds are earmarked to compensate specific types of hospitals for distinct functions and risk plans are unlikely to pay the extra costs that these hospitals incur.

The AAMC believes that the inclusion of the mission-related payments in the AAPCC rates leads to inequities in the benefit package that beneficiaries receive, creating a two-tiered system of benefits for the elderly. Many risk enrollees receive more generous benefits because plans use payments in excess of their costs to fund extra benefits to attract enrollees. Medicare AAPCC rates are not based on the plans' costs of providing services, but on historic fee-for-

service expenditures. If a plan's payments exceed its expected costs--including allowances for administrative expenses and a reasonable profit--as reported to the program, Medicare requires the plan to return the excess either to the federal government or to provide additional benefits to risk enrollees. Plans can charge additional premiums, but many choose to waive some or all the premiums associated with these additional benefits, perhaps related to local market pressures. As a result, there is variation in the benefits available to beneficiaries across the country. A recent ProPAC analysis confirms that HMOs are more likely to participate in urban areas that have higher AAPCC rates and they tend to offer more generous benefit packages than plans in areas with lower payment rates. The AAMC believes that, given the relationship between risk plan participation and payment rates, managed care plans have used the mission-related payments embedded in the AAPCC rates for other than their intended purposes, namely to provide extra benefits to enrollees and to increase operating profits beyond the normal rate of return that Medicare incorporated in the rate setting process.

The theory that risk contractors pass these mission-related dollars back to teaching and DSH hospitals is simply not borne out by the facts. Since HMOs receive the same AAPCC amount regardless of the type of provider with which they contract, they have a great incentive to systematically avoid teaching and DSH hospitals when the patient care services they provide can be obtained more cheaply at hospitals without these responsibilities. Even when teaching and DSH hospitals have contracts with HMOs, contract prices need not, and most often do not, recognize the special costs incurred in providing their special missions. Teaching hospitals simply want a level playing field to begin negotiations. They are willing and able to compete for patients in the marketplace, but without access to the special payments embedded in the AAPCC rates, they can never hope to enter into fairly priced contracts.

The AAMC understands that removing the mission-related payments from the AAPCC rates is only one issue in improving risk payment methodology. How to remove these dollars, whether at the national or individual county level, is a crucial issue and will have interactive effects with other proposed changes. Excluding the mission-related payments at the national level, essentially an across-the-board reduction, would decrease unfairly the AAPCC rates of those counties where no or little teaching or service to the low-income poor occurs. On the other hand, abruptly removing these payments at the individual county level could have significant consequences in some areas.

Despite broad agreement on the policy appropriateness of excluding mission-related payments from risk plan rates, many observers have questioned whether the newly determined rates would be sufficient to pay health plans without stunting the growth of Medicare managed care enrollment. A ProPAC analysis of 1995 data showed that AAPCC rates would decline on average 5.3 percent and in half of all counties, rates would be lowered by 2.5 percent or less. However, teaching and disproportionate share hospitals are concentrated in certain geographic areas, and in those counties, the impact on rates would be more severe. In these counties, the mission-related payments could be phased out over a transition period of a few years. Included with other proposed modifications to the methodology, such as a minimum annual update, a payment floor, a blended rate uncoupled from fee-for-service spending, and improved risk

adjustment methods, payment rates to risk plans could be made more accurate, equitable and predictable. The AAMC is working jointly with the American Hospital Association to analyze options for removing the special payments from the AAPCC rates and their interactions with other proposed changes to the methodology and would be happy to share the findings with the Subcommittee as they become available.

The AAMC recommends both near-term actions to address the immediate issue at hand, as well as longer-term actions to resolve the current Medicare payment methodology for the AAPCC. In the long term, initiatives should be undertaken to identify and study potential alternative contracting mechanisms to the AAPCC methodology. For the near term, once DGME, IME, and DSH payments are removed from the AAPCC, the AAMC recommends that separate payment methodologies, which mirror the current Medicare regulations and are administratively feasible, be applied to each component of the DGME, IME and DSH payments. This approach could be accomplished through direct payments to hospitals by continuing to use the current Medicare payment methodologies and settlement process with some relatively minor technical changes.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk plans grows. As beneficiaries increase their participation in managed care plans, or exercise other options such as Medical Savings Accounts (MSAs), and fee-for-service payments decline, the mission-related dollars lost by teaching and DSH hospitals will increase substantially. The same issues also are arising under proposals to increase enrollment in Medicaid managed care programs. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding risk-based contracts among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Reducing Medicare Payments to Teaching Hospitals and Teaching Physicians

The AAMC recognizes that unrestrained growth in Medicare spending threatens the long-term solvency of the Federal Hospital Insurance (HI) Trust Fund, and supports reforms to align trust fund income and outlays. However, the Administration's proposed changes in the Medicare and Medicaid programs would have significant effects on the nation's health care system, and especially on teaching hospitals and medical schools. Under the fee-for-service portion of Medicare, which still accounts for over 85 percent of all beneficiaries and is expected to retain a majority of the elderly for years to come, the program makes two explicit payments, IME and DGME, to teaching hospitals. The Administration has proposed reducing these payments by nearly $8 billion between FY 1998 and FY 2002. It also has proposed three GME reforms. Another proposal that would affect teaching hospitals and teaching physicians is the Administration's proposal to create incentives to control high-volume physician services, which would save $2 billion over 5 years. In the absence of a marketplace where all insurers or sponsors of patient care programs share responsibility for supporting the academic missions, the

historical, explicit payments to teaching hospitals, DGME and IME payments, take on critical importance.

Teaching hospitals also rely heavily on DSH payments, receiving about two-thirds of total payments. Changes in both the welfare and Medicaid programs are eroding the measures in the formulae used to calculate Medicare DSH payments. New measures of service to the low-income poor, such as uncompensated care, should be evaluated with an eye toward targeting DSH dollars toward hospitals that serve the indigent.

The Indirect Medical Education (IME) Adjustment. Since the inception of the prospective payment system in 1983, Medicare has made payments through the IME adjustment for the higher operating costs of teaching hospitals. While its label has led many to believe that this adjustment compensates hospitals solely for GME, its purpose is much broader. Both the House Ways and Means and the Senate Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The AAMC believes that any reduction in the current level of the IME adjustment should be proportionate to other reductions in the rate of Medicare spending. The President has proposed a reduction in the IME adjustment from its current 7.7 percent for each 10 percent increment in a hospital's resident-to-bed ratio to 5.5 percent by FY 2002, a 29 percent reduction over 5 years. Any proposed decrease in IME payments is not a reduction in the rate of increase of program spending, but is a real cut for teaching hospitals. Coupled with private sector losses, reductions in Medicaid spending and other cuts in projected Medicare payments, reductions in IME or DGME payments will force teaching hospitals to bear an unfair burden of Medicare payment reductions, making it more difficult for them to sustain their additional missions.

As the Congress contemplates adjustments to assure the solvency of the Trust Fund, payments for hospital services are principal targets. All hospitals' Medicare payments are affected by changes in the factor for updating the basic PPS prices, but only certain types of hospitals experience the effect of changes in IME and DSH payment policy. While teaching hospitals recognize the need to control Medicare expenditures to protect the long-term solvency of the program, these institutions would be affected not only by IME reductions, but also by reductions in the update factor and the erosion of DSH payments.

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While some policy makers regard the $4.3 billion in current IME funds as a source from which to obtain budget savings, it must be remembered that IME payments, while a fairly small proportion of total Medicare spending, are absolutely vital to a relatively small number teaching hospitals. ProPAC has shown that IME funding is concentrated in relatively few teaching hospitals: about 140 teaching hospitals receive one-half of all IME payments. If the level of the IME adjustment is reduced, it would have a significant negative impact on the hospitals at the very high end of the continuum of teaching intensity.

The AAMC believes that any changes in Medicare payment policy should be implemented gradually with an annual evaluation of their impact on the financial viability of different groups of hospitals. Congressional decisions on Medicare payment policies should be made in the context of their impact on the entire health care system. Non-federal COTH members account for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges. For many COTH member hospitals, Medicare payments comprise from one-quarter to one-third of all their revenue. Clearly, changes in Medicare payments will have a profound impact on these institutions.

While some policy makers have pointed to teaching hospitals' current PPS inpatient margins as reason to reduce the level of the IME adjustment, the AAMC believes, as explained earlier, that PPS inpatient margins are simply one narrow measure of financial performance. Teaching hospitals' total margins remain below those of other hospital groups. Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. ProPAC, in its March 1997 report, notes that a "large and immediate reduction in IME payments might make it difficult for teaching hospitals to support their unique missions" and has recommended that changes in the level of the adjustment should be "made gradually and monitored closely to ensure that access... is not adversely affected."

Three Proposals to Change IME and DGME Payments. Proposals to change the rules for making DGME and IME payments have been stimulated by both the need to limit the growth in Medicare expenditures and the need for an appropriately-sized and -trained physician work force. For FY 1998, the Administration has offered three separate proposals to reform GME: capping the total number of residents and the total number of non-primary care residents for IME and DGME payments; allowing GME payments to non-hospital settings; and counting resident' time spent in non-hospital settings for IME payments. Taken together, they would save the program $3.4 billion over 5 years. These proposals seek to achieve a more appropriately configured physician work force by placing limits on the total number of residents for which the program will pay, shifting the balance of primary care and specialist physicians, and encouraging training in non-hospital settings. These proposals are generally consistent with current AAMC physician work force policies.

Placing a Cap on the Number of Residents. The Administration proposes to cap both the total number of residents and the number of non-primary care residents that may be counted for IME and DGME payments. The Medicare program currently imposes no limit on the total number of

residents it will support for DGME and IME payments. While the details of this proposal are not yet available, it attempts to limit the total number of residents the program will pay for and to influence the mix of residents toward primary care specialties.

The AAMC agrees with the Administration that the size of the residency training system needs adjusting, but we believe other approaches also should be considered. Last month, the AAMC, in concert with five other national associations, issued a Consensus Statement on the Physician Work Force. It recommends a closer alignment between the number of entry level residency positions and the number of graduates of U.S. medical schools, to be achieved primarily by limiting federal funding for residency positions. Training opportunities for foreign born physicians would continue to be available, but their training would not be financed by the Medicare program.

At the same time, the AAMC believes that changes in Medicare funding must make provisions for appropriate transitional mechanisms to address the impact on crucial patient care functions of hospitals that are adversely affected by a substantial reduction in the number of residents, many of whom are graduates of foreign medical schools. For some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for residents would cause substantial access and service problems for Medicare beneficiaries. The AAMC notes that the Medicare demonstration project in New York, where hospitals that have chosen to participate in the experiment are reducing the number of residency positions by meeting annual targets in exchange for transition funding, includes a process and a time table so that patient access to services is not reduced. The New York experiment offers another approach to adjusting the GME system by uncoupling the level of funding from the number of residents for a limited period.

The AAMC is very aware that, notwithstanding the broad policy view that the nation is headed toward an oversupply of physicians, there remains a significant number of underserved inner city and rural areas. To ensure that physicians set up practices in underserved communities, we recommend that federal incentives be made available to students who pursue careers as generalist physicians and establish practices in inner city and rural areas. To the degree that decreases in the level of GME funding and residency downsizing results in program savings, the AAMC believes that savings could be used to encourage physician migration to underserved communities. The AAMC also supports increased funding for the National Health Service Corps as an inducement to practice in underserved areas. With respect to the Administration's proposed cap on the number of residents, the AAMC strongly recommends a process that would allow for new training programs and expansion of programs in certain areas. This is particularly important for the development of training sites in rural areas.

The AAMC believes that reductions in the number of residency positions, or "right-sizing" the GME enterprise, should begin with constraining or eliminating support for residents who are not graduates of accredited U.S. medical schools. This process will require difficult decisions. Hospitals that cannot reduce positions due to service demands by the populations they serve must get adequate financial assistance to maintain their patient care mission. However, after the

process is complete, the quality of graduate medical education training and the size and compositions of the physician work force will be better aligned.

Some policy makers have proposed a voucher system to both control the number of residency training positions and encourage ambulatory training. According to this plan, placing the payment in the hands of the resident would enable the trainees to choose the training site. The AAMC believes that the current system has many characteristics of a voucher system. While the resident does not possess an actual voucher certificate, the Medicare program makes a payment to the hospital only if the resident has chosen to train in the hospital's program. While a voucher system appeals to some in terms of achieving national work force objectives, many operational questions about how a voucher system would work, such as the payment amount of the voucher, the number of training years it would cover, and on what basis it would be distributed, are yet to be addressed by policy analysts.

Allowing GME Payments to Non-Hospitals. Current law regarding Medicare DGME payments explicitly states that DGME payments may be made only to hospitals. The Administration proposes to allow non-hospital settings, such as Federally Qualified Health Centers (FQHCs), to receive GME payments for primary care residents when a hospital is not paying the resident's salary. **The AAMC supports changes in Medicare DGME funding to encourage residency training for all specialties, when appropriate, in non-hospital, ambulatory sites, and believes that Medicare DGME payments should be made to the entity that incurs the cost.** Recipients of payments could be teaching hospitals, medical schools, multi-specialty group practices or organizations, such as GME consortia, that incur training costs. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization in which the program functions must determine the institutional commitment to graduate medical education. The AAMC also does not support allowing non-hospital settings to receive IME payments. The IME adjustment recognizes differences in inpatient costs between teaching and non-teaching hospitals.

Counting Work in Non-Hospital Settings for IME. Current law does not allow hospitals to count residents for IME payment purposes in settings other than inpatient hospital units or the hospital outpatient department. Many policy makers believe that this rule should be changed to remove barriers to training physicians in non-hospital, ambulatory settings. **The AAMC supports the proposal to count residents' work in non-hospital settings for IME payments.** In making this change, hospitals will be able to count residents in non-hospital ambulatory training sites for their resident-to-bed ratios. The total number of residents counted by the hospital would be capped under the Administration's plan at some historical level.

Creating Incentives to Control High-Volume Inpatient Physician Services. The Administration proposes to limit payments to groups of physicians practicing in hospitals where the volume and intensity of services per admission exceed the national median to encourage physicians to become more efficient. Medicare would withhold 15 percent of each payment for each physician service delivered by a high-cost medical staff starting on January 1, 2000. If physician groups successfully managed the volume and intensity of services during the year, Medicare would

return the withhold. If they were over the limit, part or none of the withheld funds would be returned.

The AAMC joins the PPRC and several physician organizations in opposing this proposal. The Association believes that applying a prospective withhold is not only inappropriate, but fundamentally contrary to Congressional intent and every physician's participating agreement with the Medicare program. This proposal would have a significant negative impact on both teaching and non-teaching physicians. It would unfairly focus payment reductions on only a small fraction of providers or services. This proposal incorrectly assumes that all physicians in a hospital belong to a single practice group. It introduces physician profiling as a punitive device, rather than as an educational or quality control tool. Perhaps most important, the proposal could have a serious impact on quality of care if the volume targets were set to encourage medical staffs to skimp on care. Finally, it could result in disruptions in certain hospitals as physicians switch institutions. If regional referral centers or tertiary hospitals were designated as "high cost" hospitals, Medicare beneficiaries might face limited access to needed specialized services. As the PPRC found several years ago, there is little evidence to support the notion that a state, regional, or even a local level volume performance standard would provide a better incentive for physicians to reduce costs than the national volume performance standard.

Conclusion

Fifty years ago, a revolution in medical innovation began, turning teaching hospitals and medical schools into the backbone of medical progress. An infusion of funds into the central missions of these institutions--research, education and patient care--has stimulated an era of hope and discovery. The rise of managed care, the consolidation of providers and price competition may now unravel the financial threads that hold teaching hospitals and medical schools together.

Only the federal government can create an equitable, effective system to share responsibility for the nation's health and medical progress. The AAMC believes that establishing a "shared responsibility" fund for the special missions of teaching hospitals and medical schools is a crucial and important step for all Americans. This approach to financing the special missions of academic medicine is an issue that deserves the Subcommittee's close attention.

As part of the federal responsibility, the Medicare program, since its inception, has supported a portion of the costs related to graduate medical education, setting a standard that has been in place for more than thirty years. As the bulwark of graduate medical education financing, Medicare's continued participation--on behalf of its fee-for-service and its managed care beneficiaries--is essential in a competitive delivery system. The program's policies profoundly affect how other payers view their roles in support of GME. The Congress should remember the important precedent established and maintained by the Medicare program when setting a course for the future of GME financing.

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Appendix A

The Characteristics and Roles of Teaching Hospitals

Teaching hospitals, in addition to all hospitals' mission of providing basic health services to community residents, have the responsibilities of clinical education for all types of health professionals, provision of an environment in which clinical research can flourish, and highly specialized patient care. These responsibilities are combined in many different ways in individual teaching hospitals, depending upon a hospital's mission, its role in the community, the resources available to it, its past history and its view of the future. As a result, a vast continuum of diverse teaching hospitals exists.

Graduate Medical Education. Participation in graduate medical education programs is the characteristic that, by definition, separates teaching from non-teaching hospitals. Upon completion of medical school, physicians continue their medical education by completing at least three years of training in residency programs. While some residencies are based outside the hospital, most graduate medical education is sponsored by hospitals. Medical schools and teaching hospitals have devised a range of relationships for the conduct of graduate medical education. At one extreme, the "freestanding" residency is established, staffed and controlled by the individual hospital. At other end of the continuum, the residency program is offered jointly by the medical school and one or more hospitals. Along the continuum are a variety of relationships tailored to the needs, resources, and opportunities available. In 1995, nearly 1,025 short-term, non-federal hospitals provided the training sites for over 88,000 residents and clinical fellows in graduate medical education programs. The Veterans Health Administration also supports almost 9,000 filled residency positions, or 8.7 percent of filled residency training positions in the United States.

Undergraduate Medical Education. Prior to residency training, medical students complete four years of medical school. The "hands-on" clinical education of medical students consists of clerkships in hospitals and other clinical settings during which medical students spend a fixed amount of time under the supervision of faculty and residents in various specialties. Residents contribute substantially to the education of medical students, and their presence is often critical to the success of undergraduate programs. In 1995, over 33,000 undergraduate medical students received clinical training at teaching hospitals or their affiliated educational sites.

Nursing and Allied Health Education. Hospitals also remain the primary sites for the clinical training of nurses and other allied health professionals. While classroom training for nurses is now more likely to take place in a college or university, nurses still receive the major portion of their clinical education in hospitals. More than 25 other training programs in allied health fields are widely supported by teaching hospitals, including programs for physical therapists, respiratory therapists, and emergency medical technicians.

Provision of an Environment for Clinical Research. The nation's teaching hospitals and medical schools are the backbone of innovation in American medicine because they provide the

environment for the conduct of clinical research and the introduction of new life-saving drugs, devices, and procedures into clinical practice. What is now commonly accepted medical care, such as treatment of infectious disease, came from laboratory and clinical research in academic health centers. Open heart surgery and life-saving organ transplantation were pioneered at teaching hospitals. From the use of ether in performing "painless" surgery 150 years ago, to the development of neonatal intensive care units, and the promise of gene therapy in curing inherited genetic disease, medical schools and teaching hospitals serve as locations for experimentation and development of new knowledge that benefits the world. Many of these advances began in basic research laboratories of universities and their affiliated hospitals; most of the advances were transferred to patient care as clinical research programs at teaching hospitals. After rigorous evaluation in major medical centers, many of these innovations are adopted in other provider settings. Teaching hospitals offer a natural setting for the advancement and early application of medical knowledge by bringing together seriously ill patients and research-oriented faculty physicians.

Provision of Patient Care Services. In addition to their education and research missions, teaching hospitals are, first and foremost, providers of a broad range of health care services. They provide all levels of patient care--from preventive to tertiary services. They are local institutions providing basic hospital care in their neighborhoods and communities. They also are referral institutions providing tertiary care to statewide and regional populations, as well as community service institutions caring for patients from all economic and social backgrounds. Because of their research activities, teaching hospitals house the newest and most advanced services and facilities and with residents and supervising physicians available around-the-clock, teaching hospitals often care for the nation's sickest patients.

Why COTH Member Hospitals are Different

All teaching hospitals share three common objectives: education, research and patient care. However, while teaching and non-teaching hospitals operate in the same general organizational, social and financial environment, academic medical center hospitals, defined as short-term, nonfederal members of the AAMC's Council of Teaching Hospitals and Health Systems (COTH), have distinctive organizational and service characteristics. Membership in COTH requires hospitals to sponsor or participate in at least four approved residency programs and have a signed agreement with an accredited school of medicine. Thus, COTH member hospitals, which include 75 Veterans Affairs medical centers, are the backbone of graduate medical education, training about 75 percent of all residents in the U.S.

Comparing the 276 short-term general, non-federal members of COTH that reported data to the American Hospital Association in 1994 with the 828 other teaching hospitals and 3,853 non-teaching hospitals reveals striking differences about the characteristics of COTH members. Nearly two-thirds of COTH hospitals, but less than one-half of other teaching hospitals, are located in metropolitan areas of over one million population. In contrast, over one-half of non-teaching hospitals are located in rural areas. COTH hospitals are significantly larger than other hospitals. Over one-half of COTH hospitals have more than 500 beds; in comparison over one-

half of non-teaching hospitals have under 100 beds. More than two-thirds of other teaching hospitals have between 100 and 400 beds. As large organizations with multiple responsibilities, COTH members also employ many personnel, often serving as economic engines in their local communities or regions. COTH members are primarily sponsored by non-profit organizations. About one-quarter are state university hospitals or major inner city municipal hospitals. Only three COTH members, or 1 percent, are investor-owned hospitals, while 7 percent of other teaching hospitals and 15 percent of non-teaching hospitals are owned by for-profit entities.

COTH members are major providers of patient care services and offer a wide range of hospital services. In 1994, while comprising only 6 percent of all hospitals, COTH members accounted for 20 percent of all admissions; 21 percent of all births; 23 percent of outpatient visits; and 18 percent of all surgeries performed in short-term, non-federal hospitals.

COTH members' unique responsibilities compel them to serve the needs of their communities differently than other teaching and non-teaching hospitals:

- Seventy-one percent of COTH members operate certified trauma centers, compared to only 29 percent of other teaching hospitals and 13 percent of non-teaching hospitals;

- Sixty-three percent of non-federal COTH members provide organ transplant surgical services compared to only 16 percent of other teaching hospitals and 3 percent of non-teaching hospitals;

- Ninety percent of all COTH hospitals provide both inpatient and outpatient AIDS services, while 69 percent of other teaching hospitals and only 33 percent of non-teaching hospitals provide similar services;

- Ninety-four percent of COTH members provide cardiac catheterization services compared to 68 percent of other teaching hospitals and 33 percent of non-teaching hospitals, and COTH hospitals provide similarly disproportionate amounts of open heart surgery and angioplasty services.

Teaching hospitals provide a disproportionate share of health care services to the most disadvantaged members of our society. Non-federal COTH members have 18 percent of the nation's beds, but 24 percent of all Medicaid inpatient days. In addition, COTH members provide a disproportionate share of uncompensated care. In 1993, COTH members wrote off 45 percent of the charity care ($4.9 billion) incurred by non-federal hospitals, and 27 percent of all bad debt expense.

STATEMENT OF

BRUCE C. VLADECK, PH.D.
ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON

"GRADUATE MEDICAL EDUCATION"

BEFORE THE

SENATE COMMITTEE ON FINANCE

MARCH 12, 1997

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Graduate Medical Education Reforms

INTRODUCTION

Mr. Chairman, thank you for inviting me here today to talk about the President's FY 1998 graduate medical education training proposals and the recently announced New York Graduate Medical Education (GME) demonstration project. It is an opportunity I welcome, since I have been involved in discussions of these issues for the last 20 years, as a charter member of the New York State Council on Graduate Medical Education, as a member of the Prospective Payment Assessment Commission, and in many other roles. After all these years of discussion, it is gratifying to believe that this may finally be the year in which some of these reforms come to fruition.

Medicare payments are designed to adequately pay for care provided to Medicare beneficiaries, including the direct and indirect costs of medical education. However, there is broad consensus that there is an oversupply of physicians. In addition, with the increase in enrollment in managed care and treatment in outpatient settings, many believe there is a distributional problem, with too many specialists and not enough primary care physicians in areas where they are needed. Despite the national consensus on oversupply, Medicare currently provides hospitals with financial incentives to increase the number of residents they train.

The high-quality research and medical education that occurs in our academic health centers is internationally recognized, and is something we should take pride in, especially since Medicare has played an integral role in supporting medical education. It is important that Medicare continue to play an important role. Over time, it has become clear to us that the incentives provided through Medicare payment policy have overpowered market incentives that might affect the number of residents. Some historical background on this will provide context, after which I will describe our current legislative proposals which are designed to more clearly align the incentives of Medicare payment policy with those of the marketplace.

BACKGROUND

Historically, Medicare paid for inpatient hospital services, including the training of interns and residents, on a cost basis. However, when Medicare began paying for inpatient hospital services through the Prospective Payment System (PPS) in 1983, we recognized that teaching hospitals serve a special population and that the teaching process, itself, means that care in teaching hospitals is more costly than in other hospitals. For this reason, Medicare makes an adjustment to the payment rates for Medicare discharges provided in hospitals that train residents. This adjustment, the indirect medical education (IME) payment, recognizes that the higher costs of treating patients in teaching hospitals. Under current law, the IME payment is based on the teaching hospital's ratio of interns and residents to beds. Because the hospital's IME payment is based on this ratio, the hospital will receive a higher indirect teaching adjustment for each Medicare discharge if it trains more residents. This system provides incentives for hospitals to train more interns and residents. Medicare's IME payments increased from $2.9 billion in FY 1990 to $5.1 billion in FY 1995, an increase of more than 75 percent.

The current formula for determining Medicare's indirect medical education payments provides approximately a 7.7 percent increase for each 10 percent increase in a hospital's ratio of interns and residents to beds. Studies by HCFA, the General Accounting Office, DHHS Inspector General, and the Propective Payment Assessment Commission have shown that this formula compensates teaching hospitals in excess of the additional costs of treatment. If enacted, the President's proposals would gradually bring Medicare's indirect medical education payment adjustment down to 5.5 percent in 2002, closer to the actual indirect costs of treating a Medicare patient in a teaching hospital.

When Congress created the Medicare PPS in 1982, it excluded direct hospital costs associated with approved educational activities from payment through the PPS system. Since 1985, Medicare has paid teaching hospitals for the direct costs of GME training on a per resident amount. Direct GME costs include such items as salaries and fringe benefits for interns and residents, supervisory teaching physician costs, and miscellaneous overhead associated with operating a medical residency training program. Under this payment system, Medicare determines a hospital's per resident costs in a base year and pays that amount for each intern and resident working in the hospital, adjusted for Medicare inpatient utilization. Since 1987, we have also been paying hospitals for intern and resident time spent in ambulatory training, when the resident is involved in patient care and the hospital continues to pay the resident's salary. Medicare payment for the direct costs of medical education is the second way in which Medicare provides incentives for hospitals to train more interns and residents. Medicare's direct GME payments have increased from $1.3 billion in FY 1990 to approximately $2.0 billion in FY 1995, an increase of 50 percent.

Health resource experts have focused on the overall supply of physicians, the distribution of physicians across the country, and the mix of physician specialists. Organizations such as the Institute of Medicine, the Council on Graduate Medical Education, and the Pew Charitable Trusts have raised concerns that the Medicare program is providing incentives to train too many residents. Furthermore, given Medicare's policy of paying hospitals for training, these and other organizations also have been concerned that Medicare provides incentives to train too many specialists in inpatient hospital settings. Health experts have noted that medical practice is changing; there is increased emphasis on primary care training, and the growth of managed care means a greater demand for physicians who have strong skills in providing primary care services. Just two weeks ago, the American Medical Association, the American Association of Medical Colleges, and other national medical organizations held a press conference, at which they issued a consensus statement confirming the oversupply of physicians and the need for the Federal Government to realign its GME funding policies.

At the present time, Medicare does provide some financial incentives that promote training of primary care physicians. First of all, Medicare's direct medical education payment reduces payment for training beyond the time needed to train in one specialty. Second, Medicare pays hospitals for direct medical education when a resident works in an ambulatory training site when the hospital continues to pay the resident's salary. I should note, however, that under current law we cannot count this resident time in the indirect medical education adjustment paid to hospitals. And, since the indirect medical education adjustment is typically a much larger share of the hospital's total medical

education payments, Medicare's policy of not counting resident time in an ambulatory setting for indirect medical education has been a significant *disincentive* for hospitals to provide ambulatory care training.

Historically, when hospitals were paid charges or costs by all payers, the costs of medical education were shared by all payers. However, as managed care companies and other insurers negotiate with hospitals for lower payment rates, hospitals increasingly rely on Medicare to help finance medical education. Over the next few years, we will continue to see major changes in the configuration of the health services workforce. However, the need for large sums of money to support the education of our health care providers will not disappear. While it is the responsibility of government to support activities that are essential to the welfare of its people, that does not preclude the need for other interested parties to do their part.

Senator Moynihan and others have introduced legislation to ensure that private payers make a contribution to the cost of medical education as well as the public sector. There is a great deal of interest in these proposals and we look forward to working on this issue with Senator Moynihan and other Members in this session of Congress.

THE PRESIDENT'S FY 98 BUDGET PROPOSALS

The President's FY 1998 Budget Proposals include a number of provisions affecting GME. These proposals are designed to more closely align the incentives created by Medicare payment policy with market incentives, and to help achieve the following commonly agreed-upon goals:

- 1) to stop the rapid growth in the number of medical residency positions,
- 2) to encourage more training in primary care,
- 3) to encourage more training in non-hospitals settings for all residents,
- 4) to provide more payment equity for teaching hospitals when they serve Medicare managed care enrollees.

Our legislative proposals are not designed specifically to redistribute primary care and specialty residency slots or to force programs to downsize. We do not think that it is appropriate for Medicare to become involved in the micro-management of the details and operations of individual residency programs; any attempt to do so would be fraught with difficulties. Given the dependence of many teaching hospitals on Medicare GME funding, any major or overly prescriptive changes in payment policy could have serious ramifications.

Let me now briefly describe our GME proposals in the President's FY98 Budget.

I. Cap on the Number of Residents:

The number of residents increased from 107,850 in FY 1990 to 129,434 in FY 1994, an increase of 20 percent. To stop the rapid growth in the number of residents, we would limit Medicare's payment

to the number of residency slots at each teaching hospital in the 1996 residency year (ending June 30, 1997). We also would cap the number of specialist residents at the number the program had in the same residency year. In this way, hospitals could increase their number of primary care residents, as long as they reduced their numbers of specialty residents, but not vice versa. We would also cap Medicare's payment for IME, so that the hospital could not inflate the intern and resident to bed ratio to gain additional payments by reducing its number of beds. This reform is supported by the American Medical Association.

II. Use three-year rolling average of FTEs for GME and IME payments:

We believe that many hospitals continue to increase the number of residents they train, or avoid decreasing the size of their residency classes in spite of market forces, because of the incentives inherent in Medicare payment policy. To decrease the financial impact of changing the size of their programs, we propose to base direct and indirect medical education payments on a three-year rolling average of residents, rather than on the number of residents in a program in a given year. The effect of such a formula would be to lessen the financial impact of downsizing programs. This is analogous to some of the concepts in our New York GME demonstration, which I will discuss in more detail later.

III. Make Direct GME payments available to certain non-hospital settings:

Since the proportion of care being delivered in ambulatory and other non-hospitals settings has increased dramatically in the last few years, it has become increasingly important that residents receive more training in ambulatory settings. According to the statute, however, Medicare can only make payments for direct GME to hospitals. Although hospitals have been willing to some degree to allow residents to rotate to non-hospital settings, they are not usually willing to share their GME funding. We propose to give Medicare the authority to pay certain non-hospital providers, specifically Federally qualified health centers (FQHCs), rural health clinics (RHCs), and managed care organizations (MCOs) for the direct costs of medical education. In order to qualify for these payments, facilities will have to participate in accredited teaching programs and bear the costs of the residency program (i.e., resident salaries). We realize that other non-hospital settings, such as ambulatory surgical centers and physician offices, are also important training sites. Our proposal also would give the Secretary the authority to make GME payments to other non-hospital sites in the future and would be an important step toward improved medical care access in rural areas.

IV. Allow hospitals to count residents in non-hospital settings for IME purposes:

To encourage more training in non-hospital care settings, and to eliminate the current disincentive for hospitals to allow residents to rotate to these non-hospital settings, we propose to allow hospitals to include such residents in the calculation of their IME payments. Currently, hospitals cannot include residents in non-hospital settings, other than in the hospital's own outpatient department. To prevent additional increases in Medicare's IME payments, this proposal would not allow the resident-to-bed ratio to exceed the ratio that exists in the base year. However, the hospital's payment would

not decrease if a resident were transferred to a non-hospital setting, as long as the hospital continued to pay the resident's salary. We believe this proposal will make hospitals more inclined to let residents rotate to non-hospital settings.

V. Reduce IME formula:

We also propose to decrease the IME formula to align Medicare's payments more closely with the actual additional costs attributable to teaching. Our proposal would decrease the IME payment so that instead of hospitals receiving a 7.7 percent increase in payments for every 10 percent increase in their resident to bed ratio, they would receive 7.4 percent in FY 1998, 7.1 percent in FY 1999, 6.8 percent in FY 2000, 6.6 percent in FY 2001 and 5.5 percent in FY 2002 and thereafter. HCFA, GAO and ProPAC analyses over the years have shown that an adjustment in excess of 4 to 5 percent is not empirically justifiable. There was clear bipartisan support for reducing the indirect medical education payments, and similar proposals appeared in all of the budget reconciliation bills last year.

VI. Make GME/IME payments to hospitals for Medicare managed care enrollees:

Finally, while we do achieve savings in the IME formula and GME reforms, we propose to extend our support to teaching hospitals by directly providing them medical education payments of $10.7 billion over five years for their treatment of Medicare managed care enrollees. Mr. Chairman, our proposal is very similar to the initiative you reported out last year. As you well know, under current law, Medicare managed care contractors negotiate payment rates with teaching hospitals. Many managed care contractors are not willing to pay explicitly for the costs incurred in medical education. Medicare's payment rates to managed care contractors are based on fee-for-service (FFS) spending in the county, and include Medicare spending for medical education. Under our proposal, Medicare would pay teaching hospitals directly for direct and indirect medical education. This payment would be based on the number of Medicare managed care enrollees treated by the hospital. The mechanics of this process would be simple: hospitals would provide bills for managed care enrollees, which would enable us to calculate how much GME and IME the hospital would have received for those casees under FFS. The hospital would receive a separate payment from HCFA for their managed care enrollees. This would free teaching hospitals to negotiate more competitive rates with managed care contractors, since their costs of teaching would be reimbursed separately. We look forward to working with you on this and our other proposals.

GME REFORM PROJECTS

We realize the significant impact that changes to Medicare payment policy will have on residency training programs, and we appreciate the importance of residents in the delivery of health care. For these reasons, HCFA is also supporting several projects that test medical education reforms; demonstrations are very useful in testing the appropriateness of specific payment methodologies in advance of full implementation.

The New York Medicare GME Demonstration

New York hospitals train a formidable 15 percent of the country's residents and receive 20 percent of Medicare's annual spending on graduate medical education activities, $1.4 billion out of $7.0 billion in FY 1996. In view of New York's large number of residency slots, HCFA recently announced a major Medicare GME demonstration project in New York which serves a number of important national goals. It will lead to a reduction in the overall number of residents, it will increase emphasis on primary care training and on training in ambulatory sites, and it is designed to help teaching hospitals redirect their graduate medical education programs so they can meet the demands of a more competitive health care market.

In New York, the number of residents increased 11.1 percent in the last four years. Although many hospitals report that they have been considering downsizing their teaching programs in response to competitive pressures, we have seen little actual evidence of movement. Both our actuaries and the Congressional Budget Office assume continued modest growth in the number of residents nationally over the next several years.

In New York's hospitals, teaching and service delivery missions have been highly interdependent due largely to the State's regulatory system and to the need to serve a large indigent population. In part because of favorable payments for residents under Medicare's GME rules, New York hospitals have become highly reliant on residents to provide care. In an increasingly competitive health care market, and given the widespread concern about oversupply of physicians, such a heavy emphasis on residents is no longer appropriate.

This demonstration will help New York's hospitals transition to a more focused and innovative teaching mission by providing transitional payments to assist participating hospitals re-engineer the ways they provide care by reducing the number of residents by 20-25 percent.

The project is voluntary and the requirements for participation of hospitals are quite demanding. HCFA set the overall thresholds for reductions -- while protecting primary care training -- and required applicants to present strategic plans for both training and service delivery. Participating hospitals and their medical leadership are responsible, within the demonstration's parameters, for determining the implementation strategies that fit their unique teaching missions and the service needs of their communities.

Specifically, 42 hospitals, either singularly, in joint ventures, or consortia, will participate in Phase I of this demonstration. Each applicant selected an option to decrease the number of residents they train by either 20 or 25 percent over the six-year life of the demonstration. Hospitals that agree to increase the fraction of primary care residents they train by 20 percent, or that are part of a formal consortium with coordinated GME programs, must reduce their resident counts by 20 percent. All other hospitals must reduce their number of residents by 25 percent. Participants that fail to meet the agreed-upon targets face loss of all transition payments. The number of resident slots reduced will be more than 2,000, from a base in New York of over 14,000.

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Medicare will make transition payments that will gradually decline to zero over the life of the demonstration. In any year, these payments are a fraction of, and never more than, what Medicare would have paid in the absence of the demonstration. We expect these transition payments to total around $400 million over the demonstration period, but it is important to realize that participating hospitals will in fact receive less in Medicare GME payments than they would have in the absence of the demonstration. The transition payments are not "new" money, over and above baseline spending, but are a portion of the reduced Medicare spending resulting from the reductions in resident counts from the levels assumed in the baseline. Overall, we estimate that under current law, Medicare will achieve net savings -- even after making the transition payments -- of at least $300 million, and perhaps as high as $650 million, over the six years of the demonstration. We are currently working to refine this estimate.

Over the longer run, to the extent resident reductions are permanent and to the extent participants create better training programs and more efficient and competitive service delivery infrastructures, longer term savings to the Medicare program are also possible.

Later this year we expect to develop an additional aspect of the project designed to emphasize care in ambulatory training sites. As medical care has moved to ambulatory settings, medical training should do likewise. However, developing ambulatory training -- which requires both mentors and space in clinics and doctors' offices -- is difficult, and Medicare payment policy inhibits training outside the hospital.

A number of other organizations have expressed interest in the New York project. The President's legislative proposal for basing Medicare GME payments on a three-year rolling average of the count of residents would be very similar in effect to the way hospitals are treated under the New York demonstration. This proposal could help other hospitals receive transition payments as they reduce the number of residents they train.

Utah's GME Proposal

We have been working with the medical education community in Utah as they develop a proposal for a consortium to coordinate all GME activity in the State. This consortium would set training priorities and make resource allocations for GME in the State, based on work force planning and goals. As planned, the consortium would receive funds for GME directly from Medicare and Medicaid and possibly from private insurers as well. There is currently legislation in front of the Utah State legislature to create this consortium. Once this legislation has passed, we expect to work with the medical education community in Utah to try to develop a proposal for a demonstration.

Michigan's Medicaid GME Proposal

Michigan is intending to revamp how its Medicaid program pays for GME, and we have been in consultation with them about their proposed reform. The State is striving to achieve a better alignment between the number and type of medical professionals trained and the medical needs of its

Medicaid population. Michigan would like to recapture GME funds that have been included in its Medicaid managed care capitation payments and redirect those payments to hospitals and managed care organizations that have entered into collaborative partnerships between university medical and health professional schools.

The State would use three methods in its restructured GME payment system. One would distribute funds based on historical cost of direct and indirect medical education. Another would make payments based on the number primary care residents drawing salaries at each hospital. The third would provide incentive payments to hospitals or managed care entities for innovations in health professions education. This new design does not require demonstration waivers and we have been working with the State to implement it in a way that conforms with Medicaid payment rules.

CONCLUSION

There is broad consensus among the various players on the goals for reforming Medicare payment for graduate medical education. We all agree that we need to let the market appropriately determine how many and what types of residents are trained, and Medicare should not be in the business of micro-managing our Nation's medical education programs.

The high-quality research and medical education that occurs in academic health centers is internationally recognized, and we are rightly proud of their contributions. Medicare has played an integral role in supporting medical education and will continue to do so. Clearly, there is a need for reform, and I am heartened by the level of consensus that exists around the various proposals for medical education reforms. I look forward to working with you and the other members of this Committee to pass these reforms.

COMMUNICATIONS

STATEMENT OF THE ALASKA FAMILY PRACTICE RESIDENCY

[SUBMITTED BY DR. HAROLD JOHNSTON]

The mission of the Alaska Family Practice Residency is to provide Alaskans with quality health care through the education and support of family physicians

Program History

The Alaska Family Practice Residency developed from a forum series outlining the need for primary care physicians in rural Alaska. Providence Alaska Medical Center, University of Alaska Anchorage, Yukon-Kuskokwim Delta Regional Hospital, Bartlett Memorial Hospital, State of Alaska, Alaska Native Medical Center, Anchorage Neighborhood Health Center, and numerous other hospitals, groups and private physicians came together in 1992 for this series. The history of physician turnover, isolation, and general burn out had been continuing in remote Alaska settings with out any sign of improvement for the last 45 years. With the need for primary care physicians in the bush continuing to grow, the optimum decision was to develop a primary care physician workforce trained to handle bush Alaska'a conditions, isolation and culture. The Alaska Family Practice Residency has been the result.

Throughout the program development phase, we have worked with the GME reimbursement formulas to see if we could achieve our rural health objectives and have a viable program. By current projections, the program will be subsidized over $450,000 dollars annually. That figure is attributable to high operating costs of doing business in Alaska combined with the low number of medicare beds. This is Alaska's only residency program, and no other residency is planned in foreseeable future. The demographics and reimbursement formulas simply make it cost prohibitive. However, the commitment to provide the necessary workforce combined with the bush Alaska need and conditions makes this program a correct public policy choice for Alaska.

Program Description

The Alaska Family Practice Residency is a training program for physicians to receive education and training in family medicine. The program lasts three years with eight residents per year beginning in July, 1997.

The program is based in and supported by Providence Alaska Medical Center. The program is statewide and has formal affiliations with health institutions in Anchorage and Bethel, and with the University of Alaska and the University of Washington.

The curriculum has a strong focus on transcultural medicine, intensive care unit procedures, obstetrics, telecommunications linkages, and public health and health system development.

The Rural Component

Curriculum has been designed to train physicians comfortable working in rural and remote areas. All Residents will go on rural rotations, and the lecture series will address the rural component of each topic. For example, the management of chest pain and the clinical decision-making skill, transport and stabilization issues will be taught for urban, rural and remote settings.

Additionally, residents need to be exposed to and to determine individually if the demands often placed on the village physician is within their range of ability and desire. Alaska village residents often depend on their physician in areas unrelated to health care. Depending on the location, the physician may be called on to be anything from village council member to coach. These community/cultural demands are not workable for many physicians. Residents need to have the experience to decide about this very personal part of site choice before committing to practice in a remote village.

Curriculum Highlights

Year 1
Residents will do a transcultural medicine month which will be a concentrated piece of the curriculum that trains residents in community assessments, community leadership, native health system and nonnative health system interface, public health and cultural sensitivity.

Year 2
Residents will do a rotation in Bethel for six weeks. Bethel is a town of 5000 people and is the hub for a patient service area the size of Montana. It is located 350 air miles west of Anchorage, and no roads connect any of the service area villages. Medical care is provided by Yukon-Kuskokwim Delta Regional Hospital—a 50 bed hospital staffed by 16 family physicians. This component of the resident curriculum is their first direct experience with rural health care delivery. While in Bethel, they will work with village health aides and travel to small native villages. The immersion into the native culture and rural medicine will provide residents with the necessary understanding about practicing medicine in rural Alaska.

Year 3
The third year resident will travel to another rural community in the state for actual practice site development. This experience combined with the 2nd year rotation is the maximum allowable time a resident can be away from the home site. The rural rotations will be augmented by another month of transcultural medicine which will focus on practice management issues for a rural physician. Each resident will complete a plan of action to address a remote site issue identified in their first year of transcultural medicine.

Rural and Community Services

Faculty exchanges will be a regular part of our program. As the program develops, our faculty will cover the practice of rural physicians allowing rural physicians to participate in the teaching and CME opportunities at the residency in Anchorage. Residents, faculty and rural physicians will all benefit from these exchanges as the bush perspective will be more integrated into the lecture series, rural physicians get a much needed break, and faculty will expand their rural Alaska experiences.

In Anchorage, clinical experience in the Anchorage Neighborhood Health Center will provide residents with experience in caring for the 15% of Anchorage's population that are below the poverty level and unable to access primary care services due to poverty and lack of health insurance. The Anchorage Neighborhood Health Center (ANHC), Alaska's oldest and largest community health center, serves approximately 9,000 low income individuals in the Anchorage area, but has been unable to meet all the need due to lack of capacity. The Residency will double ANHC's capacity to reach up to 70% of the needy population.

Our objective in training residents to practice medicine in rural Alaska comes out of a sincere urge from many in this state and outside of this state to see an improvement in health care for those Alaskans living in the bush. We would like to see decreases in preventable diseased like cervical cancer, lung cancer, and alcoholism. Securing certain funding for this program is a very high priority for us. It is important that GME funding changes incorporate the following elements:

- ***A carve out of GME funds from the AAPCC directed to education***
- ***Allow resident time on ambulatory rotations to be included in IME fund formulas***
- ***Do not cap the number of primary care residents funded under GME***
- ***Allow payments to non-hospital entities such as Community Health Centers for support of primary care residencies.***

American Association
of Colleges of Nursing

ONE DUPONT CIRCLE, NW, SUITE 530
WASHINGTON, DC 20036
(202) 463-6930 FAX (202) 785-8320
http://www.aacn.nche.edu

U. S. SENATE
COMMITTEE ON FINANCE

STATEMENT ON THE REDIRECTION OF NURSING EDUCATION MEDICARE FUNDS TO GRADUATE NURSE EDUCATION

On Behalf Of

AMERICAN ASSOCIATION OF COLLEGES OF NURSING
AMERICAN COLLEGE OF NURSE PRACTITIONERS
AMERICAN NURSES ASSOCIATION
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS
NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACULTIES

Hearing on Graduate Medical Education

March 12, 1997

ADVANCING HIGHER EDUCATION IN NURSING

STATEMENT ON THE REDIRECTION OF NURSING EDUCATION MEDICARE FUNDS TO GRADUATE NURSE EDUCATION

The American Association of Colleges of Nursing (AACN), representing 510 baccalaureate and graduate nursing education programs in senior colleges and universities, urges that Medicare funds now focused on entry level nursing education be redirected for clinical training of graduate nurses. This innovation would provide an on-going revenue source, not subject to the uncertainties of the annual appropriations process, to expand the production of advanced practice nurses, a vital resource for meeting future Medicare population needs.

AACN is also testifying on behalf of:

The American Colleges of Nurse Practitioners (ACNP), representing individual nurse practitioners (NPs), 16 state nurse practitioner organizations, and 6 national nurse practitioner organizations;

The American Nurses Association (ANA), representing the nation's 2.5 million nurses through its 53 state and territorial nurses associations;

The National Association of Pediatric Nurse Associates & Practitioners (NAPNAP), with over 5200 members; and

The National Organization of Nurse Practitioner Faculties (NONPF), representing over 300 nurse practitioner tracks in schools of nursing or other educational institutions.

The Committee's concern about physician workforce and the supply of residents, especially international medical graduates, is understandable in view of the extent of Medicare financial support and the types of physicians it produces. But the Committee should not overlook the relevance of other health care professionals, such as advanced practice nurses, in meeting the needs of the health care system for workforce. As the Committee examines Medicare funding and services for the nation's elderly, Medicare's lesser-known side--the system's financial support of training for nurses, physicians, and other professionals--itself is in dire need of reform. For example, Medicare supports the costs of training resident physicians with direct and indirect Graduate Medical Education funds amounting to over $7 billion per year. At an estimated $244 million in 1996 and a projected $420 million in the year 2000, Medicare is the largest single source of federal support to train America's largest health care profession--registered nurses. Yet, 70 percent of every Medicare dollar for nursing education goes to hospitals that operate diploma programs which produce entry level nurses. These payments are concentrated in Pennsylvania, New Jersey, and Ohio, and hospitals there receive nearly half of the Medicare nursing education funds. Hospital downsizing and other changes in the health care system, resulting in sicker patients discharged to home, means that the care once provided in a hospital setting with a myriad of sophisticated support systems must now be provided by professional nurses prepared to work in home and community settings.

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At the same time, the health system's increasing demand for front-line primary care, and the accelerating drive toward managed care, prevention, and cost-efficiency are spurring the nation's need for nurse practitioners, certified nurse-midwives, certified registered nurse anesthetists, and clinical nurse specialists with advanced practice skills. While there has been much discussion in the media and in Congress on how Medicare redesign may ultimately affect funding for physician residencies in the nation's teaching hospitals, nursing and other health care leaders are focusing on a concern equally as big--the need to produce sufficient supplies of advanced practice nurses for an increasingly outpatient world where more needs of current and future Medicare patients will lie. Reforming Medicare will require more effective targeting of Medicare dollars that support the training of health professionals who provide that care. Since its creation in 1965, Medicare has reimbursed hospitals for a portion of their clinical, classroom and other costs to train nurses, physicians and other health personnel with the aim of providing high-quality inpatient care for Medicare recipients. With recent and dramatic shifts in where and how health care is delivered, the time is long overdue to overhaul the other side of Medicare--its health professions education expenditures that increasingly have become irrelevant and misdirected. In fact, Medicare funds for nursing are almost impossible to track in terms of what they pay for. At no additional cost to Medicare, money presently spent to educate diploma nurses with skills limited to basic hospital service could be used to educate Advanced Practice Nurses (APNs). APNs are expert clinicians, who, based on their areas of expertise, are trained to deliver primary care, manage chronic medical conditions, and/or address other needs of the Medicare population. They include nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists. APNs are educated in graduate nurse education (GNE) programs accredited by nationally and regionally recognized accrediting bodies.

Redirecting Medicare funds to the education of advanced registered nurses not only makes clear sense for a health system dominated increasingly by the competing concerns of quality and cost. but would support preparation of the nurses in greatest demand by today's Medicare patients. In 1965 at Medicare's inception, most categories of advanced practice nursing had not yet emerged. In the years since, Medicare policy has not kept pace with the growing prevalence and documented quality and cost-effectiveness of APNs. Annually, the millions of Medicare dollars that could support the preparation of the APN instead have funded the continued production of diploma graduates.

Reports from other national organizations forecast greater demand for the APN than ever before. In a 1994 report, the Pew Health Professions Commission urged doubling the number of nurse practitioner graduates by the year 2000 to offset the shortages of primary care physicians in major metropolitan centers, rural sites, and inner cities. Among their roles, the nation's approximately 50,000 nurse practitioners (NPs) conduct physical exams; diagnose and treat common acute illnesses and injuries; provide immunizations; manage high blood pressure, diabetes and other chronic problems; order and interpret lab tests; and counsel patients on adopting healthy lifestyles. NPs work in gerontological, pediatric, family health, women's health areas, and some have independent practices. In 48 states, nurse practitioners can prescribe medications, while several states have given NPs authority to practice independently without physician supervision

or collaboration. NPs care for the nation's elderly in urban and rural practices and in clinics, correctional facilities, the military and private practice settings.

Thus, NPs often provide services of the type most needed by Medicare patients: primary care at easily accessible, community based sites. These quality services are available at lower cost than would be possible in a hospital setting.

In a report recently released by the Institute of Medicine (IOM) on nurse staffing in hospitals and nursing homes, an IOM panel urged that increasing numbers of registered nurses with advanced practice skills be utilized in outpatient and inpatient settings to meet the growing demand for RNs with management, leadership, and supervisory abilities. The panel noted that advanced practice registered nurses such as clinical nurse specialists not only provide high-quality and cost-effective care, especially for patients with complicated or serious clinical conditions such as Medicare patients, but are well-skilled for the sophisticated levels of practice required in today's hospitals. They work on multi-disciplinary teams and deliver a continuum of care across settings rather than focus on a "single event" of hospitalization. IOM also recommended that nursing home care be enhanced through increased presence of gerontological nurse specialists and nurse practitioners. While Medicare's role in nursing homes is limited, the patient population in these facilities is primarily Medicare eligible.

Similarly, in a 1996 study commissioned by the Association of Academic Health Centers entitled *The U.S. Health Workforce: Power, Politics, and Policy,* author Jerry Cromwell came to the strong conclusion that nurse anesthetists "will be in greater demand over the next ten years, and in significantly greater demand depending on how fast and how hard the public and private payers push." It is clear that the current educational system is simply not capable of producing an adequate supply for future Medicare beneficiaries.

This statement supports redirecting Medicare funding for hospitals operating diploma programs into APN education. The following Medicare changes would provide a greater benefit to the Medicare population.

1. Redirecting eligibility to add "jointly operated" programs and to phase out Medicare funding of diploma programs.

Since the inception of Medicare, nursing education has shifted from hospital on-the-job training almost entirely to community colleges, senior colleges, and universities. At present, Medicare reimbursement for nursing education programs is limited by the "provider-operated rule," which directs most of the funding to hospitals that operate diploma programs that produce entry level nurses who are trained in hospital oriented care. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed, such as nurse practitioners, clinical specialists, and others. Educational costs of these new providers are, with one exception (nurse anesthetists), not eligible for Medicare reimbursement now. Consequently, reimbursement eligibility requirements should be changed to include "jointly-operated" (provider-academic) programs that incur costs for APN education. To be eligible for reimbursement, Medicare providers (hospitals) would have to: 1) demonstrate that they incur

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clinical costs for the support of graduate nurse education programs, and 2) have a written contractual agreement with the program's academic partner institution. These requirements would provide some accountability for where the money is going and that it addresses demonstrable clinical costs.

Cost items for determination of Medicare's share of reimbursement could include student stipends, costs of nursing clinical faculty, and supervision of APN students at the clinical site. (Now the students, school, and clinical sites bear these costs.) Determination of the specific cost of education would be based on a modest stipend, an appropriate ratio of training faculty to students, and faculty and supervisory salaries.

Major problems for APN education are the need for resources to cover costs of clinical faculty and the availability of clinical training sites. A 1995 Lewin-VHI study "Expanding the Capacity of Advanced Practice Nursing Education-Final Report," identified several factors affecting the ability of APN programs to expand.

The availability of sites for appropriate clinical education is the single most significant factor in determining a program's ability to expand its APN capacity. According to the study, sites are becoming limited due to competition with other APN programs and graduate medical education programs; effects of managed care; and practical limitations on the distance between schools and clinical sites.

A major concern is the effect of managed care on clinical training of health practitioners in community sites. As managed care systems proliferate, providers have increased their panel sizes in order to meet the demand to be more productive. This results in a loss of qualified preceptors, as providers are unwilling to take time away form seeing patients in order to coach students. NP faculties have reported that the requirements to see more patients per day has become a major barrier in recruitment of preceptors.

AACN member schools in Arizona, Maine, New York, and Ohio report that their APN programs are competing with medical schools, residency programs, and physician assistant programs for clinical sites and do not fare well, because these other health professional programs are reimbursing the sites or providing tuition vouchers. Nursing schools report that, in some cases, practitioners who have traditionally agreed to precept students are turning away nursing students and taking students from programs that can reimburse them for their preceptor role.

Another factor affecting the ability of APN programs to expand is the availability of clinical faculty, including clinical coordinators and preceptors, in order to expand programs. Redirection would facilitate APN programs and clinical facilities to hire additional clinical faculty to expand the number of APNs in training, and would help to eliminate today's waiting lists for many graduate nursing programs. Medicare reimbursement for APN clinical education would give practice sites an incentive to take on additional APN students for clinical training, particularly if the numbers of specialty physician residencies are reduced. If the clinical site is being reimbursed for these faculty costs, the burden would be lifted from both that site and the school of nursing and placed properly upon the health care system. The lifting of restrictions on

Medicare funding for nursing education would result in increasing the production of APNs, (both in terms of number and their program completion time) making cost-effective care more readily available to the Medicare population.

In addition, the ability of programs to pay stipends for APN students to defray some student living and education costs have demonstrated to be effective in moving part-time students into full time study and a more rapid completion of graduate nurse studies (According to AACN's *1996-1997 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, 70% of all master's students and nurse practitioner students are enrolled on a part-time basis.) In return for a stipend, the graduate nursing student would provide care for the provider's patients, much as physician residents do. Providing education programs with flexibility to support APN students with stipends during their graduate preceptorships recognizes the similarity of their training to physician resident training. Unlike medical residency programs, most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. In almost all cases, APN students are RNs licensed to practice in a variety of patient settings, and most have practice experience as well.

2. Clarifying "provider" definition to include outpatient facilities serving Medicare patients.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery for Medicare populations evolving beyond the hospital to more accessible and lower cost, community based sites, it is clear that ambulatory care facilities, as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. As training evolves to other settings, hospital payments alone will be inadequate to reimburse provider training costs. Support for training in these settings where primary care is delivered is critical. The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers, ambulatory care facilities, community health clinics, health maintenance organizations, and public health departments. Reimbursing clinical sites for training APN students recognize the value of their services to Medicare patient care. As the number of specialty resident physicians is reduced, APNs are well positioned to deliver many services formerly performed by resident physicians, as well as nursing care, and case management.

Under this proposal, facilities that incur clinical costs for support of APN education would have access to Medicare funds, but only for the portion of the cost attributable to the Medicare patient population. Thus, for a site with 30% Medicare patients, 30% of the training costs would be eligible for reimbursement. (This is the same formula used now for Medicare support of diploma nursing education.) Medicare funding would provide resources for added clinical faculty to expand the numbers of APNs in training, and promote quality service to the Medicare beneficiary. With an increasing proportion of older Americans and increasing incidence of chronic illnesses, APNs are precisely the type of health professional the Medicare population will need for its primary care, management of chronic medical conditions affecting older people, and

patient education to help this population avoid injury and expensive hospitalization or nursing home care.

The APN is a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment. This is the time to shift Medicare funding toward the recognized need for advanced practice nurses. Other organizations support the redirection of Medicare dollars to APN education. In April 1995 and again in February 1997 the Physician Payment Review Commission (PPRC) recommended that advanced degree nursing programs operated by four-year colleges and universities be eligible to receive Medicare funds that otherwise would be available only to hospital-operated programs. In July 1995 the Association of Academic Health Centers (AAHC) supported the allocation of funds for graduate nurse education by directing Medicare funds towards APN programs. Supporting APN clinical education with Medicare dollars also has been urged by the Graduate Nurse Education Coalition, representing 11 national nursing organizations.

Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. For diploma nursing programs that receive Medicare pass through support we agree that a phase out over five years would be equitable and would avoid harming current students in those programs. The redirection of these funds to APN education requires no new Medicare expenditures and could actually reduce expenditures. By recognizing only clinical costs of APN education and limiting eligibility to full-time APN students, costs would decrease substantially. Funding levels should not be reduced for those APN programs that currently benefit from Medicare support, such as nurse anesthetist programs. Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of a health care delivery system that is changing for Medicare and other patients.

As the Committee considers Medicare reform and health care workforce issues, nursing groups ask that it examine the current structure of Medicare funding for nursing education and graduate medical education and the on-going changes in health care delivery. We urge your support for APN education at a time when these nurses are in great demand and capable of meeting the sophisticated needs of today's Medicare beneficiary.

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AACOM

American Association of Colleges of Osteopathic Medicine
Office of the President

5550 Friendship Blvd., Suite 310, Chevy Chase, MD 20815-7231 • (301) 968-4142 • FAX: (301) 968-4101

March 7, 1997

The Honorable William Roth
Chairman
Finance Committee
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

On behalf of the seventeen colleges of osteopathic medicine that are members of the American Association of Colleges of Osteopathic Medicine (AACOM), I would like to take this opportunity to present our views on proposed changes to the ways in which Medicare makes payments for graduate medical education. I also request that this statement be included in the hearing record. AACOM supports all Congressional initiatives that both assure the provision of the best health care in a cost-effective delivery system and that maintain the capacity to educate outstanding practitioners to provide these services at a level of quality that the American public expects and deserves. We recognize the responsibility of the Committee to examine the health care delivery system, with an eye toward increasing fiscal responsibility while maintaining its effectiveness in meeting the health care needs of all Americans. Congress is rightfully concerned about developing a reasonable health care workforce policy and at the same time achieving dollar savings. We believe that our recommendations are entirely consistent with these objectives, as well as the recommendations of the Council on Graduate Medical Education, and in large part with the Pew Health Professions Commission and Institute of Medicine reports. In addition, these views are in concert with the Consensus Statement on the Physician Workforce issued by the American Medical Association, American Osteopathic Association, American Association of Colleges Osteopathic Medicine, Association of American Medical Colleges, Association of Academic Health Centers, and National Medical Association on February 28, 1997.

While there is general agreement that the nation is faced with an oversupply of specialists, the fact remains that this oversupply does not currently extend to primary care practitioners. In addition, the continued existence of medically underserved areas and the problem of physician maldistribution cannot be ignored.

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Primary care has always been the centerpiece of osteopathic medical education. Indeed more than 60% of osteopathic physicians practice in primary care fields. Nearly 30% of the full-time faculty in all 17 colleges of osteopathic medicine teach family medicine, pediatrics, or internal medicine. This fact is even more evident among the adjunct faculty of our schools. Half of these faculty teach in primary care departments. Similarly, AACOM member schools have a long history of dedication to training primary care physicians to work in America's smaller communities. Throughout the continuum of an osteopathic medical student's education, both undergraduate and graduate, the principles of primary care are imparted and reinforced.

The concept of continuum in medical education (i.e., a philosophical thread running from the first day of medical school through the last day of residency training) itself has been pioneered in the osteopathic medical community through the mechanism of consortia. The advantages of consortia are numerous. The organizational structure and governance of residency programs are improved dramatically through increased coordination among local or regional organizations directly and indirectly involved in residency training. Better integration of all medical education can be realized. This is especially important to ensure continuity of medical education and to expose undergraduates early to the practice settings that they will encounter as physicians. The consortium increases residents' ambulatory training experience through the participation of ambulatory care facilities and with the exposure to managed care delivery systems. The consortium is better equipped to implement community-wide programs to achieve specific training goals related to physician distribution by specialty and location.

The osteopathic medical profession has taken a leadership role in creating systematic, rational formation of consortia through implementation of the osteopathic postdoctoral training institution (OPTI) concept. The OPTI is a graduate medical education system by which all osteopathic GME organizations will be reviewed. The OPTI is required to consist of at least one AOA-accredited hospital and at least one accredited college of osteopathic medicine. Osteopathic teaching hospitals are typically smaller, community-oriented facilities frequently joined with colleges of osteopathic medicine to form consortia which serve to increase the availability of graduate medical education (GME) for training in family medicine, internal medicine and other primary care disciplines within the profession. Community health centers, ambulatory clinics, and managed care organizations will create opportunities for the required ambulatory components of the training programs and may assist with resource support. The required partnership within an OPTI between the traditional hospital training site and the osteopathic medical school is unique in establishing and assuring a necessary bond of clinical and didactic training.

Several osteopathic consortia are already in existence and have demonstrated their extraordinary ability to address the special health care needs of their communities, while enhancing the educational experiences of their residents, interns, and medical students. The Michigan osteopathic educational system has had a long and successful history. A formal consortium in GME was developed in 1989 as the Consortium for Osteopathic Graduate Medical Education and Training (COGMET). The transition from COGMET as a post-doctoral consortium to the development of the Michigan Statewide Campus System (SCS) including a pre and post doctoral consortium was realized in July,

1996. Eventual progression of SCS to the Michigan OPTI will stress the success and potential of a true collaboration and partnership of trust and accountability between 16 community based hospital teaching institutions and the Michigan State University College of Osteopathic Medicine.

The Ohio University Centers for Osteopathic Regional Education (CORE) System is another example of an OPTI, and a fully developed medical education consortium. This consortium began operation in July, 1995 and was preceded by one year of intensive planning. It is an interstate OPTI with four colleges of osteopathic medicine and thirteen hospitals. The CORE system is founded on the philosophy that emphasizes collaboration, shared resources, consensus decision-making, shared responsibility, and a commitment to excellence in osteopathic undergraduate and graduate medical education.

These and other osteopathic consortia are working examples of the efficacy and flexibility of the OPTI model and demonstrate the value of further utilization and development of consortia for GME training on a national level. We believe that followup studies of these consortia have demonstrated their ability to enhance access, efficiency, and the integration of medical education. We look forward to sharing these findings with you.

In order to reorganize graduate medical education to be consistent with the changing realities of medical practice, the American Association of Colleges of Osteopathic Medicine (AACOM) believes that Medicare's GME payments could be directed to graduate medical education consortia, which would be voluntary arrangements of medical colleges, internship and residency programs, teaching hospitals and other care settings where GME is conducted. Payments would be drawn from the current direct and indirect pools of money. This proposal redirects the flow of existing funds, and does not require the Federal government to increase its Medicare GME contributions.

The Congress recognized the value of consortia in last year's Medicare reform legislation (H.R. 2491) under section 2433. Although we strongly agree with the intent of this provision, we believe that a change in the definition of a "qualifying consortium" is appropriate to reflect the objectives that the Congress seeks to achieve. Specifically we would urge that in order to qualify for Federal GME reimbursement a consortium must consist of the following:

- One or more colleges of allopathic or osteopathic medicine as approved by the Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA);
- One or more hospitals approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA);
- Non hospital ambulatory sites such as community health centers, medical group practices, or managed care entities;
- Three residency training programs or two residency training programs and an

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osteopathic internship program; and

- At lease one primary care residency program.

In view of the movement of medical education toward consortia, particularly in the area of GME, AACOM feels that consideration should be given to allowing the direction of funding for GME to the consortium.

In addition to our views on the value of consortia, AACOM would also like to make the following recommendations:

1) Consistent with the Council on Graduate Medical Education's (COGME) views and the position articulated in the Consensus Statement on the Physician Workforce, we urge that graduate medical education providers be paid Direct Medical Education (DME) and Indirect Medical Education (IME) payments for all residents who are graduates of U.S. medical schools. Support for graduate medical education positions for International Medical Graduates (IMGs) should not be at the expense of U.S. medical school graduates (D.O. or M.D.).

2) The DME and IME components of the Average Adjusted Per Capita Cost (AAPCC) should be removed from Medicare capitation rates and these GME funds used specifically for GME purposes. Currently, Medicare GME funds are factored into AAPCC payments which go to managed care contractors (HMOs) whether they have teaching programs or not.

3) We recommend that Direct Medical Education payments be made without reference to a base year. The DME base year of 1984 is becoming increasingly outdated and inappropriate especially for osteopathic graduate medical education programs. There is great variation of DME payments around the country. Osteopathic medicine has traditionally been at the lower end of that curve and allopathic medicine had been at the upper end. In 1984, osteopathic graduate medical training sites utilized large numbers of volunteer educators. That number has decreased significantly in the last eleven years with many volunteers being replaced by paid faculty. Accordingly, costs associated with osteopathic GME have risen. We, therefore, suggest that in place of the base year formula per resident amounts be based on an adjusted national average of per resident costs.

4) The trend in many cases is to make increasing use of ambulatory care settings for teaching purposes. While all specialities could benefit from education in ambulatory settings, it is critical for the primary care disciplines, namely, family medicine, general internal medicine and pediatrics that reimbursements for this training be increased to recognize the higher cost of ambulatory education. To encourage ambulatory care training, GME payments should be made for primary care physicians' resident time

spent in walk-in clinics, physicians' offices, group practices, community health centers, and managed care facilities.

Finally, Mr. Chairman, we would like to comment on the Administration's proposal. The President's fiscal year 1998 budget contains a number of recommendations affecting Medicare's payments for the costs of graduate medical education (GME). While we believe that some are steps in much needed new directions, others raise concerns. We encourage the Committee to look closely at these issues and make decisions that reflect a reasonably coherent physician manpower policy, one that is designed to produce the types and numbers of physicians we will need in the future.

The budget would reduce the payments for indirect medical education made to teaching hospitals. These changes in the overall formula would undoubtedly reduce the level of spending, but they are not tied to any overall manpower goal. For example, since the education of more primary care physicians is a frequently cited policy aim, why can't the change in IME funding be directed in ways that would encourage the output of primary care physicians? Measuring the output of a hospital's training programs and rewarding those institutions with a higher percentage of primary care programs could be a way of encouraging more such efforts.

The proposals to cap residency positions at the hospital level while still allowing growth in primary care does seem to be a positive direction, but appears inflexible. The consolidation of health facilities now underway could change the mix of residency positions in a community. A hospital based cap could get in the way of sensible, community wide consolidation of residency training programs. Perhaps a national cap on training programs would lead to the same budgetary results, without too much rigidity. Incentives for primary care training could be part of the new formula.

The Administration seems to recognize the difficulty of ensuring that Medicare dollars earmarked for GME actually reach their intended targets. AACOM believes that this is particularly a problem with Medicare managed care programs, a relatively new, but very fast growing, phenomenon. Establishing a GME trust fund which could receive payments from managed care, along with other resources, is our preferred strategy. All payers should, we believe, contribute to the common good derived from GME. We believe that the President's approach will not lead to the necessary apportionment of payments.

The President proposes a commission to look at academic health centers. Absent from the language creating this commission is any references to the osteopathic medical profession or osteopathic medical education. We recommend that this omission be addressed prior to enactment. The contributions of the academic centers of osteopathic medicine are well known and need to be incorporated explicitly in this section.

The President' budget would permit Medicare GME funds to be paid to other locations outside the hospital, but on a very limited basis. The budget is silent on payments to consortia, our preferred strategy for changing the current incentives in graduate medical education. As we have stated, consortia offer the major opportunity to change the incentives of the players and move our graduate

medical education system into much needed new areas.

Mr. Chairman, AACOM believes that all these recommendations will generate significant savings while targeting taxpayer funds to train primary care physicians in both hospital and non-hospital settings. Thank you for your consideration and AACOM looks forward to working with the Committee to achieve these objectives.

Sincerely,

Douglas L. Wood

Douglas L. Wood, D.O., Ph.D.
President
American Association of Colleges of Osteopathic Medicine

STATEMENT OF THE

AMERICAN ASSOCIATION OF DENTAL SCHOOLS

The American Association of Dental Schools (AADS) is pleased to present our perspective and recommendations concerning Graduate Medical Education (GME) policy as it impacts upon dental education. The AADS represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted. The AADS is the only national organization that speaks exclusively for dental education.

The AADS believes it is important to have a long-term policy on Graduate Medical Education, including the continued role of Medicare funds. While the major focus in this area is on physician training issues, it is important for the committee to consider the impact on other primary care professions such as dentistry.

Since the beginning of Medicare, dental residency training has been part of graduate medical education (GME) payments. For over thirty years, Medicare GME payments have been vital to meeting the dental health personnel needs of our country, and enhancing the quality of care for Medicare beneficiaries. It is essential that this assistance be continued because a financially sound graduate dental education system is a prerequisite to the provision of oral health care to the elderly, disabled, medically compromised, and other special needs populations.

It will be helpful for the Committee to understand the nature of oral health care provided to patients in these dental residency programs. Treatment of dental caries (decay) in children was the predominate concern of dentists in the past. Today, as a result of the advances made in preventive oral health care over the last four decades, an increasing number of people are retaining their teeth for a lifetime. This change in the nature of dental disease requires today's dentists to master a broader range of treatments and to understand the implications of an ever increasing number of medical conditions and prescription drugs on the oral health of patients, especially the elderly.

Dental caries and periodontal diseases are bacterial infections which, like pneumonia and other bacterial diseases, require treatment. Oral cancer is more common than most people realize and kills more people each year than cervical cancer. Untreated dental diseases cause millions of hours of lost productivity and impede employability. Oral health affects general health, and treatment of dental diseases is often a medical necessity.

In fact, there are numerous medically necessary oral health care issues relevant to the oral health care provided by residents in "GME programs" that are financially supported by hospitals. Medically necessary oral health care is a direct result of, or has direct impact on, an underlying medical condition. It includes care directed toward control and/or elimination of pain and infection and re-establishment of function. Two dramatic examples are:

> For those receiving radiation therapy, a dental abscess or infection frequently becomes uncontrolled and destroys the surrounding bone or even the jaw itself, leading to disfigurement and sometimes death. Rampant decay is a common complication of head and neck radiation, and such treatment may result in destruction of the salivary glands.
>
> Bacteria from oral infections can spread through the blood stream and attach to the heart valves of those with congenital or acquired heart defects and to other prosthetic replacements in patients. This can lead to life-threatening complications. This is also important in transplant and cardiovascular surgery.

AADS recommendations on GME are also premised on the reality that hospital dental residency programs and dental education clinics have unique financial problems which make delivering this care difficult. Federal reimbursement for dental services is extremely limited. As a result, clinics operated by dental education programs in teaching hospitals and ambulatory care sites have become a "safety net" for patients without insurance or resources to pay. Unfortunately, the increasing amount of unreimbursed dental care provided by these training programs places them at serious financial risk. Added to that are the market trends in managed care, which may impact upon the number of patients seen by academic health centers and dental clinics located in teaching hospitals. While dental education clinics offer an excellent model of ambulatory-based primary care, any significant reduction in GME support for dental training will cripple the nation's dental training infrastructure. Without Medicare GME support for dental training, many hospital-based dental residency programs would close due to the high cost of training, unreimbursed care costs, and lack of other funding mechanisms. This would result in inadequately trained dental personnel for the medically necessary dental treatment of patients, and inadequate medical/dental interactions in health care delivery settings.

There are several Medicare GME issues that are currently under discussion in Congress that raise important concerns for the AADS.

1. **Proposals to reduce or cap the number of Medicare funded residencies (as in the Administration's FY 1998 Budget Request)**

AADS Recommendation: **Such proposals are typically aimed at reducing the number of physician residency positions. Any moratorium on the number of positions or reduction in the number of positions should explicitly refer to only "allopathic or osteopathic positions."** Or, alternatively, the number of Medicare funded first-year dental residency positions could be limited to 100 percent of the number of graduates from U.S. dental schools each year.

Dentistry does not have the over-specialization problem that medicine has experienced. Over 80 percent of practicing dentists are primary care generalists. In addition, the dental residency numbers are small: in 1995-96, the first-year enrollment for all recognized dental specialty programs and General Dentistry residency training programs was 2,441.[1]

The 1995 study of dental education by the Institute of Medicine makes the following recommendation:

> **"The committee recommends that post-doctoral education in a general dentistry or specialty programs be available for every dental graduate, that the goal be to achieve this within five to ten years, and that the emphasis be on creating new positions in advanced general dentistry and discouraging additional specialty residencies unless warranted by shortages of services that cannot be provided effectively by other personnel." (Recommendation 7, "Dental Education at the Crossroads", January 17, 1995, Institute of Medicine).**

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[1] Compared to physician training, dentistry does not have a "foreign dental graduate" concern with such individuals filling an excess number of residency positions. In fact, for the 1994-95 academic year, over 80 percent of dental residents were either U.S. or Canadian citizens.

It is important to note that in 1993-94, the first-year enrollment for all accredited postdoctoral dental programs represented only 63 percent of all dental school graduates for that year. Unlike medicine, there are not enough dental residency positions for all dental school graduates. The implication of this IOM recommendation is quite clear: hold steady on the number of dental specialty positions, but increase the number of General Dentistry positions. Even among dental specialties, the training needs should be re-assessed periodically for potential future increases in the number of positions.

Therefore, GME policies aimed at physician training needs should not be superimposed upon dental education. The solution for dental training is not to "downsize" specialty residency positions for the sake of "primary care", as is the goal of the current New York GME demonstration project. Therefore, it would be most appropriate to consider special dental residency provisions in all GME policy arrangements. **Medicare legislation passed by the House and Senate in 1995 provided for an exemption for dental residencies from the "freeze" on physician training positions.**

2. Proposals to foster primary care training in ambulatory sites (as in the Administration's FY 1998 budget proposal)

AADS Recommendation: **Any targeting of funds to primary care training at ambulatory sites should include primary care dental residency training programs (General Dentistry, Pediatric Dentistry, and Dental Public Health) supported by dental schools.**

Some proposals define primary care residency positions as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. If this definition is to be "revived" for future policy settings, it should be modified to include other primary care training, such as dentistry.

The Administration's current proposal is to provide Direct GME payments directly to ambulatory care sites that support primary care residencies. **This proposal should explicitly include dental school clinics.** Dentistry conducts a significant amount of postdoctoral training outside the hospital. Many programs are developing rotations to community health centers; this experience has led to an increased number of primary care dental residents to practice in underserved communities upon completion of the residency. Also, consortia initiatives would help move additional training to ambulatory sites, rather than continuing a hospital preference for all residency training. While many hospitals currently support ambulatory-based care and off-site rotations, and receive GME funding for this, the current system is a disincentive for a community-based clinic to initiate and financially support a residency program.

Dental residency training differs from physician training in that approximately one-half of all positions are located in dental schools. Dental school clinics are not eligible for Medicare GME funding. Yet, these are integral to supporting the dental training goals highlighted above. As with hospital-based residents, these school-based residents play an important role in treating underserved populations, including low-income and elderly patients. A recent study of several dental school clinics prepared for the AADS found that the median household income of clinic patients was $13,800 - $15,600 per year, with two-thirds reporting a household income of $20,000 or less. Eighteen percent of the patients were age 65 and over. AADS estimates that over 600,000 Medicare eligible individuals are treated each year in dental school clinics.

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For most Americans, the primary care team includes a physician and a dentist. If either is unavailable, the patient has an access problem, as treatment of the entire body must include the oral cavity. The 1995 IOM report on dental education specifically states that "oral health is an integral part of total health, and oral health care is an integral part of comprehensive health care, including primary care."[2] General Dentistry and Pediatric Dentistry residency are the dental parallel to family medicine and general pediatrics.

General Dentistry training programs provide a one- to two-year clinical and scientific experience which provides residents with additional expertise in various dental specialties and hospital dentistry. General Dentistry residents learn to care for the oral health needs of those requiring specialized or complex care, such as the developmentally disabled, high-risk medical patients, and those with infectious diseases. As a result, graduates of these programs refer to specialists less often, which is critically important in rural and undeserved areas. Eighty-seven percent of those trained in General Dentistry residencies remain in primary care practice. An evaluation of the Health Resources and Services Administration's General Dentistry residency training grant program found that such residents treated four times the number of developmentally disabled, six times the number of medically compromised, and 26 times the number of HIV/AIDS patients when compared with dentists in private practice. It was also recently estimated that annually there are almost 400 more General Dentistry residency training applicants compared to the number of available positions.

Pediatric Dentistry training programs provide a two- or three-year experience for the treatment of children, including those with developmental disabilities or complicating medical problems. Pediatric Denistry programs often are the only source of oral health care for poor children. While preventive oral health care for children is one of the great successes in public health, there is still unmet need. Twenty-five percent of the pediatric population experiences 75 percent of the dental disease, which is concentrated in low-income, minority populations. Dental disease among children affects the ability to concentrate and thrive in school. This is particularly tragic since through the use of preventive measures, such as sealants, cavities are largely preventable. There were 181 first-year enrollees in Pediatric Dentistry residencies in 1995-96. Approximately one of every three applicants for Pediatric Dentistry positions is turned away, and the number of positions has not expanded in the last 20 years.

Dental Public Health residencies are generally one year programs that prepare trainees for leadership roles in the control and prevention of dental disease and the promotion of oral health through organized community efforts. It is the form of dental practice that treats the community rather than the individual as a patient, and is analogous to preventive medicine training. Although small in number, these trainees are vital to the nation's dental public health infrastructure.

3. Proposals to establish an all-payer trust fund

AADS Recommendation: The AADS is fully supportive of such an approach, provided that all types of dental residency programs currently eligible for support under Medicare Graduate Medical

[2] For purposes of the Primary Care Service Obligation in the Exceptional Financial Need (EFN) and Financial Aid for Disadvantaged Health Professions Students (FADPHS) scholarships operated by HRSA, training in General Dentistry, Pediatric Dentistry, or Dental Public Health are considered "primary care" activities that fulfill this requirement.

Education law and regulations would be supported under the new fund. As noted, dental education clinics service many populations in addition to Medicare beneficiaries, including Medicaid recipients and the un- or under-insured "working poor".

As in medicine, dental residency training sites incur additional costs because of the education that takes place as care is delivered. Moreover, some of the oral health services provided for Medicare patients, while not reimbursed under the Medicare program, are essential to the successful outcome of a medical procedure. For example, dental residents provide consultations on transplant patients to assure that there are no oral infections that would jeopardize the operation. Thus, the dental consult, while not reimbursed under Medicare, is critical for the patient (the AADS believes it should be supported by all Medicare contracts, including managed care contracts).

If an all-payer medical school trust fund is considered, there are compelling reasons to provide similar funding for dental schools. There are numerous factors that have made dental schools expensive to operate as they provide both training and valuable patient care. Dental school clinics have become a significant part of the safety net for people unable to access dental care in the private sector, as well as those with significant medical complications that increase the complexity of providing oral health care. Dental school clinics provide care to patients with complex medical conditions, such as HIV infection, diabetes, genetic and developmental disabilities, heart diseases, etc., while often incurring large unreimbursed costs. Significant free care and consultations are provided by dental school faculty and residents to affiliated hospitals. Rising dental school tuitions have increasingly subsidized clinic losses in recent years; as a result, dental school tuition and indebtedness is higher than that of medical schools. Over the past 10 years the proportionate share of state and federal support for dental schools has dramatically declined. A modest federal investment in dental education, via a trust fund, would be critical to the viability of the nation's dental schools.

4. Creation of GME advisory groups

AADS Recommendation: Any such group should include representatives from the American Association of Dental Schools. Alternately, development of an advisory group focused solely on dental training issues should be considered.

Although the overall numbers are small, dental residency programs are organized differently from medical residency programs, and would require knowledgeable persons on such an advisory committee. This is especially true since dentistry is not represented on, or analyzed by, the Prospective Payment Assessment Commission, the Physician Payment Review Commission, or the Council on Graduate Medical Education. It is vitally important to ensure that physician-focused solutions are not inadvertently imposed on dental residency training with subsequent negative effects. It is essential that non-physician training such as dentistry have input on decisions as to how GME funds are dispersed.

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If the Committee has any questions about this testimony, please contact Mr. Scott Litch, AADS General Counsel and Assistant Executive Director, Division of Government Affairs, at 202-667-9433 (ext. 123) or <LitchS@aads.jhu.edu>.

American College of
Preventive Medicine

PROVIDING
LEADERSHIP IN
DISEASE PREVENTION
AND HEALTH
PROMOTION

March 27, 1997

Editorial Section
United States Senate
Committee on Finance
Washington, DC 20510

1660 L STREET NW
SUITE 206
WASHINGTON DC 20036-5603
(202) 466-2044
FAX (202) 466-2662
E MAIL info@acpm.org

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Region 8

To Whom It May Concern:

Recently the American College of Preventive Medicine (ACPM) submitted testimony for the record for the March 12, 1997 hearing on Graduate Medical Education. ACPM is the national medical association of physicians whose primary interest and expertise are in disease prevention and health promotion, areas vital to protecting and improving the nation's health. I am writing to inform you that the Association of Schools of Public Health (ASPH) and the Association of Teachers of Preventive Medicine (ATPM) endorse this testimony.

ASPH represents the 28 schools of public health which constitute a primary source of comprehensively trained public health professionals and specialists in short supply to serve the federal government, the 50 states and the private sector. ATPM is the national professional association dedicated to advancing individual and community health promotion and disease prevention in the education of physicians and other health professionals. According to the Pew health professions commission, managed care will increase the need for public health professionals. According to D-HHS, there are "significant shortages" of professional and academic faculty in the public health fields of epidemiology, biostatistics, environmental and occupational health, public health nursing, and preventive medicine.

I would appreciate your inclusion of this letter with the ACPM statement to the record. Thank you for your assistance with this matter.

Sincerely,

Suzanne M. Leous

Suzanne M. Leous
Director of Public Affairs
American College of Preventive Medicine

ACPM

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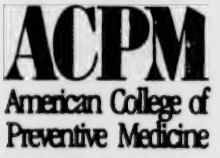

Providing Leadership In Disease Prevention And Health Promotion

STATEMENT OF

THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Submitted to

COMMITTEE ON FINANCE
UNITED STATES SENATE

For the record of the hearing on

GRADUATE MEDICAL EDUCATION

March 12, 1997

1660 L Street, NW • Suite 206
Washington, DC 20036-5603
(202) 466-2044 • FAX: (202) 466-2662

INTRODUCTION

As Congress turns its attention to the physician workforce needs of the nation as it relates to reform of the Graduate Medical Education system, **The American College of Preventive Medicine (ACPM) urges Congress to consider the unique aspects of physician training in preventive medicine and public health as it studies and recommends a system of financing graduate medical education that will meet the needs of the 21st century.** ACPM is the national medical association of physicians whose primary interest and expertise are in disease prevention and health promotion. Specialists in preventive medicine are uniquely trained in both clinical medicine and public health. They have the skills needed to understand and reduce the risks of disease, disability and death in individuals and in populations groups. Physicians trained in preventive medicine work in public health and community agencies, in primary care settings, in workplaces and in academia. The College membership constitutes a major national resource of expertise in disease prevention and health promotion, areas vital to protecting and improving the nation's health.

ACPM strongly supports payment for graduate medical education through a new accountable system separate and distinct from reimbursement for patient care. Such a system should provide for training in preventive and population-based medicine in the variety of settings where such training takes place and should be financed equitably by all health care payers, both public and private. Particular attention must be paid to supporting the training of physicians in disease prevention and health promotion, through residency training in the specialty of preventive medicine.

DO WE NEED MORE PHYSICIANS TRAINED IN PREVENTIVE MEDICINE?

Every major study of national health workforce needs has concluded that there is a shortage of physicians trained in preventive medicine. The October 1992 report of the Council on Graduate Medical Education (COGME) reported continued shortages in the field of preventive medicine and recommended increasing the percentage of physicians trained and certified in preventive medicine as a national goal. COGME's June 1995 report recommended upweighting Medicare graduate medical education payments for preventive medicine residents.

In addition to the need for more physicians trained in the specialty of preventive medicine, *there is a need for more training in prevention in all the other medical specialties, especially in primary care*. In many cases, those specialties are initiating efforts to strengthen prevention education, particularly in relation to individual patient care. Specialists in preventive medicine, who have skills in population-based prevention as well as individual preventive interventions, can assist the other specialties in the further development of education in prevention for residents and medical students alike.

The importance of placing greater emphasis on prevention of disease and disability in our nation's health system is universally acknowledged and the need for more physicians prepared to

provide leadership in prevention has been consistently documented. The Third Report of the Pew Health Professions Commission in particular recommends that all health professions schools include the social and population-based health sciences, which are the underpinnings of preventive medicine, in an evidence-based approach to clinical work, and that the traditional public health disciplines and clinical medicine be brought together to address the needs of integrated systems of care. These objectives are identical to those of preventive medicine, which long has worked to bridge the gap between the individual and population health perspectives. Preventive medicine residency programs, medical school departments of preventive and community medicine, and schools of public health have a long history of experience in teaching and research in these disciplines and much to contribute to educating a physician workforce equipped to practice medicine well in managed care environments. However, our current system of financing physician training severely impedes our ability to produce physicians skilled in prevention and the population-based health sciences.

HOW CAN WE TRAIN MORE PHYSICIANS IN PREVENTIVE MEDICINE?

The current system of financing for graduate medical education is inconsistent with training needs in preventive medicine. Of particular importance is the fact that Medicare reimbursement for graduate medical education costs is available only to those few programs where residents can be counted toward a hospital's training costs. Most training takes place in non-hospital based settings. Therefore, most preventive medicine residency programs do not receive funds from Medicare or other traditional sources of graduate medical education financing.

Many preventive medicine residency programs report that they turn away qualified applicants because they lack the funds for residents' stipends. The capacity of existing programs to train physicians is only about two-thirds funded. It is, therefore, essential that reforms to graduate medical education financing take into account the distinctive characteristics of training and practice in preventive medicine.

WHAT IS PREVENTIVE MEDICINE?

Prevention, in its broadest sense, is practiced by all physicians and other health professionals who help their patients stay healthy. Preventive medicine, however, is also a distinct medical specialty, one of 25 recognized by the American Board of Medical Specialties.

The specialty of preventive medicine is based on our knowledge that promoting health and preventing disease require work with both individuals and communities. It is the only medical specialty whose objective is to equip physicians to care for both individuals and populations. The distinctive aspects of preventive medicine include knowledge and competence in:

- biostatistics

- epidemiology
- environmental and occupational health
- planning, administration, and evaluation of health services
- the social and behavioral aspects of health and disease
- the practice of prevention in clinical medicine

The American Board of Preventive Medicine grants certificates to physicians who have successfully completed three years of supervised training, one year of work experience, and a written examination in any one of three areas: general preventive medicine/public health; occupational medicine; or aerospace medicine. Specialists in general preventive medicine/public health focus their skills on population groups, such as the residents of a particular community or state, or the patient population of a managed care plan, health center or hospital. Occupational physicians focus on health and safety in the workplace, while the community associated with aviation, including passengers, is the domain of the aerospace physician. There currently are about 4200 physicians board-certified in preventive medicine.

Preventive medicine specialists work in a wide variety of settings, including public health and community agencies, organized health plans and health maintenance organizations, outpatient and primary care settings, and academia. These physicians usually engage in multiple activities, including disease surveillance, planning, administration and evaluation of disease prevention and health promotion programs, quality management and outcomes measurement, research, teaching, and direct patient care.

HOW ARE PHYSICIANS TRAINED IN PREVENTIVE MEDICINE?

There are 87 preventive medicine residency programs accredited by the Accreditation Council for Graduate Medical Education. These include 43 in general preventive medicine/public health, 41 in occupational medicine, and three in aerospace medicine. The first of the three years of training is in clinical medicine. Most preventive medicine residency programs do not offer this first year, so residents complete it in training programs in other specialties, usually a primary care specialty. The second and third years consist of academic training in the fundamental disciplines of preventive medicine and supervised practicum experiences. Rotations take place in a wide variety of public and private settings, including outpatient facilities, health departments, managed care organizations, and worksites. About 500 residents currently are engaged in some phase of training in an accredited preventive medicine residency.

Physicians in specialties other than preventive medicine also acquire skills in prevention and the population-based health sciences by studying in academic programs in schools of public health or medical schools. There are 27 accredited schools of public health and 14 accredited graduate programs in preventive medicine/public health located in medical schools.

Accredited preventive medicine residencies are located in a variety of institutions. About half of the programs in general preventive medicine/public health and occupational medicine are

located in medical schools. The department conducting the training may be called a department of preventive medicine, or family and community medicine, or occupational and environmental medicine. About 20% of residencies are located in schools of public health. The remainder are in health departments, military or other federal facilities, or hospitals. The three aerospace residencies are run by or closely connected with military facilities.

It is important to note that all but a handful of accredited residencies are not in teaching hospitals. Residents learn through working under supervision in community and outpatient settings, where prevention is most effective. Therefore, traditional sources of financing for graduate medical education through reimbursement for hospital inpatient services are not routinely available to preventive medicine residencies.

RECOMMENDATIONS

We support strongly two key recommendations of both the Pew Commission and the Institute of Medicine. **First, payment for graduate medical education should be severed from payment for patient care.** In preventive medicine and public health, the "patient" is often the community or an enrolled population. The interventions that preventive medicine and public health physicians conduct measurably improve the health of groups of people, often by preventing disease, yet the Medicare GME financing system has never enabled payment for training in population-oriented practice. In order to account for the growing diversity of training sites and training activities, it is essential that funding for residency training follow the resident, not remain as a component of reimbursement for inpatient care.

Second, all payers, not simply the federal government, should contribute explicitly to funding of graduate medical education. This is important both as a matter of equity and as a means of establishing accountability for the numbers, types, and quality of physicians that are trained.

CONCLUSION

The paroxysms of change that are sweeping our health care system require new breeds of health professionals trained to manage not just the care of individual patients, but also the health status of entire populations. *Physicians trained in preventive medicine and public health are leaders in such efforts, and the programs that train them are committed to working to meet the needs of a rapidly evolving marketplace.* These programs can thrive if they receive equal access to funds for the costs of training, from which they have historically been almost completely cut off. An investment of a tiny percentage of the six billion dollars that Medicare alone spends to subsidize inpatient graduate medical education will enable preventive medicine and public health to help meet the challenges of balancing cost, quality and access in new health systems.

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American Hospital Association

AHA

Liberty Place
Washington Office
325 Seventh Street, N.W.
Washington, DC 20004-2802
202-638-1100

FOR THE RECORD

Statement
of the
American Hospital Association
before the
Committee on Finance
of the
U.S. Senate
on
Graduate Medical Education

March 12, 1997

The American Hospital Association appreciates this opportunity to present our views on graduate medical education on behalf of AHA's nearly 5,000 hospitals, health systems, networks and other providers of care.

GME AND DSH

GME (Graduate Medical Education) and DSH (Disproportionate Share Hospital) are separate but related issues that, during budget discussions, are usually stirred into the same "alphabet soup" as other budget line items. But GME and DSH are more than just acronyms in the federal budget. In America's communities, especially urban communities, these programs serve two very important missions: teaching our future physicians, and providing a lifeline to health care for people with no other place to turn.

Graduate Medical Education -- There is a full array of teaching hospitals in this nation: university-based academic medical centers, hospital-based independent academic medical centers, affiliated community teaching hospitals, VA medical centers, and military hospitals. These teaching hospitals incur significant direct and indirect costs in operating physician training programs. The direct costs include stipends and benefits for residents, salaries and benefits of supervising faculty, costs directly associated with providing the GME program, such as clerical personnel working exclusively in the GME administrative office, and allocated institutional overhead costs, such as maintenance, and depreciation.

Indirect costs are those incurred in providing an appropriate environment for clinical education. They include the higher cost of patient care that is inherent in treating a much higher proportion of severely ill patients. Teaching hospitals also maintain a broader scope of specialized services and stand-by capacity, often on a round-the-clock basis. And, because teaching hospitals are usually in large urban areas, land, labor and operating costs are usually higher than elsewhere. Indirect costs also include the reduced productivity of the hospital staff, because they are helping educate residents, and the diagnostic tests and other services that residents may order during their learning experience.

Since its inception, Medicare has recognized and supported the additional costs these hospitals incur in sponsoring and conducting residency training programs for physicians. Medicare's support for GME can be broken down into two parts: direct graduate medical education (DGME) payments, which help cover the direct costs of providing clinical education and are based on the number of residents; and indirect medical education (IME) payments, which cover the extra patient care costs that teaching hospitals incur, and are based on the ratio of residents to hospital beds.

Disproportionate Share Hospitals – Hospitals care for patients without regard for their ability to pay. The federal government, through Medicare and Medicaid, has explicitly supported such uncompensated care by targeting additional funds toward certain types of hospitals that serve a disproportionate share of the poor. A decade ago, Congress mandated an explicit payment adjustment in the Prospective Payment System for hospitals that serve large numbers of low-income patients. One rationale for this DSH adjustment was to compensate hospitals for the costs they incur in treating poor patients, who often are unable to get routine care or early intervention and, as a result, are sicker when they reach the hospital.

Another rationale for the adjustment: Congress had become increasingly concerned that certain hospitals were at risk of closing as a result of treating large shares of low-income patients, and began to view the DSH payment as a way to mitigate that concern. The payments were seen as helping to maintain access to care for low-income Medicare beneficiaries and other patients.

The reason that GME and DSH are so often lumped together in policy and budget discussions is simple: because most teaching hospitals are located in urban areas, they provide care to greater numbers of low-income patients. Ninety-three percent of all DSH payments go to large hospitals in urban areas. And teaching hospitals receive about 65 percent of all DSH payments.

THREATS TO THE DUAL MISSION

The federal government is under pressure to reduce the rate of growth in health care spending, especially in light of the predicted bankruptcy of Medicare's Part A Hospital Trust Fund in 2001. But proposals to slow the growth in Medicare spending pose a direct threat to the funding of uncompensated care and clinical education.

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At the same time, the marketplace for medical care is changing: from competing on the basis of service to competing on price; from fee-for-service to capitation; and from inpatient care to ambulatory and community care. Each of these changes has significantly affected the current structures that support uncompensated care and clinical education. In addition to federal budget constraints, these marketplace trends will continue to undermine historical private sector support for the important community service role that GME and DSH hospitals play.

MAINTAINING THE FUNDING COMMITMENT

If the Medicare program were to reduce its historic commitment to support hospital costs for physicians-in-training and uncompensated care, other payers might use the Medicare policy as justification for reducing or eliminating support for these costs. Therefore, it is critical that Medicare continue to provide a benchmark for support of the educational and uncompensated care costs of teaching hospitals.

However, Congress and the Administration have often viewed Medicare DSH and GME payments as targets for program savings. This year is no different. In the Administration's current budget proposal, the President proposes to reduce spending for clinical education by capping the number of resident positions and by reducing IME payments to hospitals.

Unfortunately, recent ProPAC hospital financial performance data may encourage the belief that reductions in payments to hospitals can be achieved without inflicting pain. This is not true.

Many hospitals are struggling financially -- so reductions in Medicare payments to hospitals *will* hurt. First, it's important to note that ProPAC's findings apply solely to Medicare *inpatient* services. Second, at the same time ProPAC reported these Medicare PPS inpatient margins, it also estimated that approximately *forty percent of the nation's hospitals lose money when they treat Medicare inpatients*.

More important, 20 percent of hospitals have negative *total* margins, meaning that, overall, they lose money on all patients served. Government payments cover less than the cost of providing care. In the aggregate (including both inpatient and outpatient services), Medicare pays only 97 cents on the dollar, according to ProPAC. Medicaid pays even less. For roughly 1,000 hospitals, representing one in five of the nation's hospitals, Medicare and Medicaid combined represent more than two-thirds of total revenue. Seventeen percent of these hospitals are sole community providers; another 16 percent are located in the urban core of metropolitan areas. Many are already in weakened financial positions, with roughly 10 percent of these hospitals experiencing bottom-line losses for *three years in a row*, considering all sources of revenue.

Clearly, it's inaccurate to assume that all hospitals are faring well under the Medicare program. Any Medicare reductions will have an adverse impact on a significant number of hospitals, including teaching hospitals.

CHANGING THE STRUCTURE OF GME/DSH SUPPORT

Also threatening clinical education and uncompensated care: the shift of Medicare beneficiaries from fee-for-service to managed care arrangements. The Congressional Budget Office projects that almost one-quarter of all Medicare beneficiaries will be enrolled in a managed care plan by the year 2002. As a result, a growing share of Medicare payments to hospitals will likely come through the managed care gateway, having an ever-increasing effect on teaching hospitals and other caregivers that will feel the pinch of reductions in Medicare managed care payments.

The "Carve-out" -- When Medicare beneficiaries join managed care plans, Medicare pays an up-front, monthly, per-person amount based on the adjusted average per capita cost (AAPCC). The AAPCC is a formula by which Medicare determines the average cost of providing care to beneficiaries in a particular area. The payment also includes what Medicare traditionally spends on DGME, IME and DSH payments.

However, the rates that a plan negotiates with a hospital do not necessarily include these DGME, IME or DSH payments that the hospital would traditionally receive. In addition, the plan may direct patients away from the hospitals to a lower-cost site of care -- because the plan receives the same AAPCC amount regardless of the provider with whom it contracts. In either case, there is no requirement that the health plan use the portion of the AAPCC that results from clinical education and uncompensated care payments to support these provider costs. As a result, the health plan often benefits financially if it can avoid using hospitals that support medical education.

The hospital -- which is directly incurring the costs of providing clinical education or uncompensated care -- does not receive the funds that Medicare intends to help pay for those costs. That is why the AHA strongly supports removing the GME and DSH payment amounts included in the AAPCC and making those payments directly to the entities that incur the costs of graduate medical education programs. We applaud the Administration for including such a carve-out in its budget proposal.

GME Trust Funds -- The president's budget proposals do not, however, address the need to fundamentally change the way that medical education is financed in this country.

Recognizing that payment systems are changing, Congress in 1995 proposed new trust funds for medical education, which would be supported by Medicare payments as well as general revenues. While this approach was an important step, the use of general revenues could result in funding being affected by federal budgetary pressures rather than the needs of patients and graduate medical education programs.

The AHA believes a trust fund for graduate medical education is an appropriate vehicle for supporting a broader array of training sites that are better suited to contemporary needs of

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residency programs. Residency programs began in the inpatient units of teaching hospitals. Over the past two decades, an increasing amount of residency training has moved to ambulatory training sites, both hospital-based and elsewhere within a community. Medicare has recognized hospital-based training, both inpatient and outpatient. It has also recognized hospital-supported programs in non-hospital sites. Nevertheless, there is a need to expand support for residencies in ambulatory training sites, home and community service sites, and long-term care sites. In addition, the training provided under such a fund should be broadened to include not just physicians, but nurses and other health care practitioners.

A federal trust fund for graduate medical education should be supported not by general revenues but by public and private payers. Unless such a fund is established and adequately supported, teaching hospitals will have to choose between being price-competitive by reducing their educational responsibilities, or retaining their responsibilities and being priced out of the market.

Resident allocation -- In the past several years, a number of reports and recommendations have urged the federal government to limit the number of residents-in-training and to allocate positions by specialty to teaching hospitals. While this approach may have been consistent with the health planning legislation of the early 1970s, it is inappropriate to the market-driven changes occurring today. Hospitals are adapting to changes in their local communities. Any effort to superimpose a national resident allocation structure on local, market-based reforms will produce unintended and harmful results. Hospitals are already revising residency training programs to better match the needs of their markets. The AHA believes there is no need to enact a federal system that allocates residencies to local communities or teaching hospitals.

Calculating DSH payments -- The DSH payment that Medicare pays hospitals for treating large numbers of low-income patients is calculated using what is called the DSH Index -- a formula that takes into account a hospital's Medicare inpatient days, and the number of Medicaid inpatient days for which Medicaid has paid a hospital, as proxies for the number of low-income people served by a hospital.

The AHA believes that the Medicare DSH payment should represent the cost of caring for low-income people, and of maintaining access to health care for these people. In other words, the DSH payment should be based on the number of patient days furnished to Medicaid recipients -- known as "Medicaid-eligible" days -- and not on the number of Medicaid inpatient days that Medicaid actually pays a hospital -- known as "Medicaid-paid" days, which is the current basis for DSH payment today. The number of days a hospital furnishes to Medicaid patients -- which, especially as managed care grows, is often greater than the number of days Medicaid actually pays for -- is the appropriate measure.

Current law states simply that Medicaid "days" should be used in the DSH calculation. The Health Care Financing Administration (HCFA) has interpreted this to mean that the Medicare DSH payment should be based on the inpatient days Medicaid pays for -- which is defined differently in each state. However, the Department of Health and Human Services has lost in

four federal courts of appeal -- the Ninth, the Eighth, the Sixth, and the Fourth -- on HCFA's interpretation. In each case the court has sided with hospitals, determining that the Medicare DSH adjustment should be based on the number of days provided to Medicaid patients. The Ninth Circuit was particularly pointed, saying that "Patients meeting the statutory requirements for Medicaid do not cease to be low-income patients on days that the state does not pay Medicaid inpatient hospital benefits. Thus it is illogical to conclude that Congress intended that only Medicaid-paid days serve as proxy for low-income patient days."

The president's budget, unfortunately, seeks to keep in place for two years the current method of determining DSH payments. This, in effect, locks in for two more years the use of "days paid" rather than "days eligible." The AHA urges this subcommittee to reject the administration's proposal and clarify the law so that it requires the calculation of the Medicare DSH payment to be based on Medicaid-eligible days.

Another point on the DSH calculation: In the current environment of managed care, keeping track of hospital inpatient Medicaid days has become more difficult -- resulting in often understated Medicaid burdens for hospitals. Under Medicaid managed care many hospitals do not know whether the patient seeking care is a Medicaid recipient. Also, state-based Medicaid waiver programs have changed certain eligibility rules, bringing new population groups into the program. And discussions about restructuring Medicaid adds uncertainty to a hospital's ability to track Medicaid inpatient days when calculating Medicare DSH.

Therefore, we believe that keeping track of which patients are covered by Medicaid should be the responsibility of the managed care plan that has contracted with Medicaid to provide care for those patients. Because the plan receives payment directly from Medicaid for Medicaid-eligible patients, and then in turn pays the hospital for that recipient's care, it seems logical that the plan would be more easily able to track those Medicaid-eligible patients than the hospital.

Policy changes in Medicaid and welfare, along with more health care being provided on an outpatient basis, raise another question: Should the DSH adjustment itself be reviewed? A re-examination of the mechanics of the adjustment may be useful in order to ensure that the adjustment continues to meet its mission in light of the many dramatic changes health care is going through.

CONCLUSION

Hospitals and health systems are directly affected by the dramatic changes in health care. In 1985, there were 5,732 community hospitals in the United States. By 1995, that number had fallen by almost 10 percent to 5,194 facilities. Over the same time period, trends in the use of hospital services have changed, primarily in a shift from inpatient care to outpatient services: annual admissions to community hospitals declined from 33.4 million to 30.9 million; the average length of a hospital stay fell from 7.1 days to 6.5 days; the number of outpatient visits almost doubled from 219 million to 414 million.

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Because demand for care will continue to increase as the number of beneficiaries grows and the average age of beneficiaries rises, further rationalization of our health care system must be undertaken carefully. Certainly, we cannot preserve Medicare by weakening the hospitals and health systems that serve Medicare beneficiaries, that teach our future physicians, and that take care of our nation's poor and uninsured.

If the federal government turns away from its traditional role of supporting clinical education and uncompensated care, private payers may also try to avoid those costs. No one opposes hospitals providing these services, but few are willing to accept the responsibility of helping pay for them.

As a result, federal initiatives to control health care costs, balance the budget, and extend the life of the Part A trust fund place government payments for uncompensated care and graduate medical education at risk. They also erode the likelihood of critical support coming from private payers. We can't let that happen.

These two missions are helping provide care to millions of Americans. It is important that the current budget discussion keep in mind our national commitment to care for people with no place else to turn, and to include improving the structure of the GME/DSH payment system so that we can maintain that national commitment for generations to come.

National Association of
Children's Hospitals

LAWRENCE A. McANDREWS, FACHE
President and Chief Executive Officer

N · A · C · H

Statement

Lawrence A. McAndrews

**FINANCE COMMITTEE STATEMENT ON
GRADUATE MEDICAL EDUCATION**

March 20, 1997

The National Association of Children's Hospital (N.A.C.H.) is pleased to have the opportunity to submit testimony to the Senate Finance Committee on graduate medical education under the Medicare program and the need for reform. N.A.C.H. is a national association devoted to addressing the public policy challenges to the missions of our nation's children's hospitals, representing over 100 institutions, including freestanding children's hospitals, children's hospitals that are part of larger institutions, and children's speciality hospitals. N.A.C.H. is affiliated with the National Association of Children's Hospitals and Related Institutions (NACHRI).

N.A.C.H. joins with the American Association of Medical Colleges in its support of a "shared responsibility" approach to financing graduate medical education (GME) and has consistently supported a policy that all entities that pay for hospital and health-related services assume their share of such financing. Both the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) agree. The federal Council on Graduate Medical Education (COGME) has recommended all-payer funding as well.

Children's Hospitals with Separate Provider Numbers

The purpose of this statement is to bring to the Committee's attention the critical urgency of such funding, including interim measures if needed, for one subset of teaching hospitals -- freestanding children's teaching hospitals; i.e., those not sharing a provider number with another adult hospital or system. These institutions include over 40 acute care children's hospitals and 13 children's specialty hospitals.

Although relatively few in number -- less than 1% of hospitals -- the former make a significant contribution to graduate medical education. They train over 5% of all residents nationally, over 25% of all pediatricians, and over half of all pediatric specialists. They are major, academic teaching hospitals, with agreements with accredited schools of medicine and residency programs which are, on average, the

401 Wythe Sreet, Alexandria VA 22314
(703) 684-1355 Fax (703) 684-1589

An Affiliate of the National Association of
Children's Hospitals & Related Institutions

same size as major teaching hospital programs overall. Their teaching intensity, measured using a ratio of residents to beds, is almost twice as great.

They share the same missions of patient care without regard to medical or economic need, education and research as other major, academic teaching hospitals, and they face the same pressures from a financial environment that is increasingly price competitive. There is, however, one notable difference. These children's hospitals face these pressures without the buffer of Medicare's support for GME.

The Need for GME Support

Because children's hospitals see very few Medicare patients, only children with end stage renal disease, children's hospitals with separate provider numbers receive little Medicare GME. Using data from the Hospital Cost Report Information System (HCRIS) updated to 1996, the Lewin Group found that these children's hospitals received an average of just $230 per resident from Medicare compared to an average of $77,370 per resident for teaching hospitals overall. (see attached table)

Graduate medical education is largely financed through patient care revenues, and the federal government is the largest explicit financing source through Medicare. Indeed, Medicare has become the bulwark for graduate medical education as other purchasers are becoming increasingly unwilling to pay more to teaching hospitals to account for these costs. These other purchasers include Medicaid, which is generally experiencing a substantial decline in support for GME with the demise of fee-for-service and the shift to managed care.

Their rapidly growing inability to cover GME costs, combined with their responsibilities for low-income and specialized care, are taking a toll on children's hospitals. In 1995, the average total margin for the acute freestanding children's hospitals -- the difference between total revenues and total expenses -- was 2.37%, compared with average total margins for all hospitals and major teaching hospitals, according to ProPAC, of 5.6% and 3.7% respectively. The children's hospitals' average total margins were even lower than those of disproportionate share hospitals in large urban areas (3.6%), demonstrating the value of Medicare's payment adjustments, including GME.

Proposals for Reform

Like other providers, children's hospitals are adapting to a market-driven health care system. However, reducing costs and managing efficiently cannot alone erase the competitive disadvantage brought about by added responsibilities of education, research, and specialized and low-income patient care.

The freestanding children's hospitals with separate provider numbers which do not benefit from the current federal commitment to GME financing through Medicare represent about half of our Country's major pediatric academic medical centers. It is their combined missions that enable them to serve as regional referral centers and sources for innovation in children's health care, benefiting all children. Their ability to sustain these missions depends on an approach to federal GME financing which can recognize their needs.

Two innovative approaches to fund the costs of medical education, which could realize this goal, did emerge in the 104th Congress. First, with the leadership of the Ways and Means Committee, H.R. 2491, the Balanced Budget Act of 1995, would have created a Teaching Hospital and Graduate Medical Education Trust Fund consisting of five separate and distinct accounts. Three of the five accounts would have been funded by appropriated general revenue, and the Medicare program would have contributed funds to the two other accounts. The Ways and Means Committee explicitly recognized that the use of general revenue funds would prove an opportunity to address the GME costs of children's hospitals and directed that they be considered in mechanisms for trust fund allocations.

Second, another approach to broader-based financing of GME was taken in S. 1870, the Medical Education Trust Fund Act of 1996, introduced by Senator Daniel Patrick Moynihan (D-NY). Senate Moynihan has again introduced the bill as S. 21, the Medical Education Trust Fund Act of 1997 in the 105th Congress. The bill would establish an all-payer trust fund for graduate medical education, establishing five accounts, including accounts for teaching hospitals and one for medical schools. Companion legislation (H.R. 881) was introduced in the House of Representatives by Representatives Nita Lowey (D-NY) and Louise Slaughter (D-NY).

N.A.C.H. strongly supports the creation of a trust fund for graduate medical education and the establishment of a broader-based financing mechanisms for teaching hospitals which can encompass children's hospitals. As the Committee considers these and other proposals for GME reform, N.A.C.H. looks forward to working with its Members to achieve this goal. While there would be a number of technical issues to decide, N.A.C.H. has worked with the Lewin Group to model an approach which demonstrates that commensurate federal GME funding could be provided to children's hospitals with little technical difficulty, even under the current system, if some source of non-Medicare Hospital Insurance Trust Fund support were provided. Such support would take a major step toward leveling the increasingly tilted playing field for these pediatric institutions.

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Estimated DME and IME Payments Before Adjustments to Children's Hospitals

DME Payments

	All	Non-children's	Children's
Aggregate: 1993	$1,619,482,349	$1,618,584,048	$898,301
Aggregate: 1996	$1,766,199,904	$1,765,220,221	$979,683
Per hospital: 1996	$1,664,656	$1,758,187	$17,187
Per resident: 1996	$22,325	$23,583	$230

IME Payments

	All	Non-children's	Children's
Aggregate: 1993	$3,790,889,425	$3,790,889,425	$0
Aggregate: 1996	$4,354,845,617	$4,354,845,617	$0
Per hospital: 1996	$4,104,473	$4,337,496	$0
Per resident: 1996	$55,045	$58,180	$0

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NATIONAL
ASSOCIATION
OF PUBLIC
HOSPITALS &
HEALTH
SYSTEMS

Testimony of the
National Association of Public Hospitals
& Health Systems

on Graduate Medical Education
Committee on Finance
U.S. Senate
Washington, D.C.

March 12, 1997

The National Association of Public Hospitals & Health Systems (NAPH) represents over 100 of America's metropolitan area safety net hospitals. These hospitals and systems are uniquely reliant on governmental sources of financing to support care to Medicare, Medicaid, and uninsured, low income patients, providing over 90 percent of their care to these populations. They also provide many preventive, primary and costly tertiary services to their entire communities, not just to the poor and elderly. These services include a wide variety of around-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

As the health care market undergoes revolutionary change in how it delivers and pays for health care services, two missions -- training physicians and providing health care to low income, uninsured individuals -- will remain the responsibility of a few hundred hospitals and health systems that have shouldered this burden for decades. Governmental payers, like Medicare, have long recognized the importance of these missions and the need to support them with separate DSH and GME payments. As the health care market becomes more competitive and as payment rates increasingly reflect whatever plans or payers can negotiate with providers of care, the importance of explicit, adequately-financed funding streams for these missions will be essential to the survival of safety net and teaching hospitals and health systems.

Our comments are summarized in four areas:

First, using data from our annual survey, NAPH will highlight the important mission of safety net hospitals and how their ability to meet that mission is being impacted by changes in the health industry. Recent market trends indicate there is increasing competition for Medicaid business (particularly low cost Medicaid business) while an ever-shrinking group of safety net providers shoulder most of the uncompensated care burden -- a burden that is growing steadily.

Second, NAPH supports a "shared responsibility" approach to financing graduate medical education which treats GME as a public good. This approach would require contributions from all payers of health care, not just Medicare and, thus, should distribute GME funding based on all patient care. We support legislation introduced by Senator Moynihan (S. 21) which would accomplish this goal. We urge that any physician workforce reforms that Congress considers as part of proposals to restructure GME financing be balanced with maintaining access to care in underserved communities. Proposals to limit financing for international medical graduates (IMGs) or specialists must recognize the unique role that residents supervised by attending physicians serve in safety net hospitals for communities with limited or no access to private practice physicians.

Third, the Medicare DSH formula needs to be changed to reflect new circumstances in the changing health care system. In particular, NAPH recommends that Congress adopt the approach suggested by the Prospective Payment Assessment Commission (ProPAC), which would include all elements of low income care costs, including uncompensated care, in the qualifying formula. Additionally, Medicare DSH payments must continue to be adequately financed for those providers which truly shoulder a disproportionate burden of low income care. Medicare DSH and GME payments must be carved out of the capitated amounts paid to risk contractors and made directly to hospitals that are fulfilling those missions.

Fourth, we ask that as the Committee considers the budget, Medicaid cuts not be part of the package. Growth in the Medicaid program has slowed considerably in the last year. Due to the implementation of welfare reform legislation, safety net hospitals are faced with significant losses of Medicaid revenues as legal immigrants lose Medicaid eligibility. Further, the delinking of the enrollment process for welfare and Medicaid will result in fewer healthy Medicaid recipients in the risk pool in states with Medicaid managed care. The impact of further cuts in the program or a shift to per capita caps would be devastating. At a minimum, we ask that a targeted group of hospitals treating the highest volumes of low income patients be protected from cuts in the Medicaid DSH program.

NAPH Members Provide Remarkable Levels of Both Inpatient And Outpatient Care

Perhaps the most striking characteristic of safety net hospitals is the tremendous volume of both inpatient and outpatient services they provide. On the inpatient side, in NAPH's most recent member survey, 90 hospitals reported total staffed beds of almost 40,000 for an average of 442 per hospital, total admissions of 1.4 million and total inpatient days of 10.9 million. To place this volume of care in perspective, in comparison to the average hospital in the 100 largest cities in the U.S., the average NAPH member reported 30 percent more admissions, 39 percent more inpatient days, and an occupancy rate (75 percent) that was 11 percent higher.[1]

Contrary to a sometimes-held misconception of safety net hospitals as primarily inpatient facilities, these institutions have always been the family doctor for large numbers of low income and uninsured patients, providing large amounts of primary and preventive care. In 1995, just 67 NAPH members provided an astounding total of 22 million outpatient visits, only 4 million of which were emergency room visits. Compared to the average hospital in the 100 largest cities, NAPH members provide a full 68 percent more outpatient visits.

Care To Low Income And Uninsured Patients Is On the Rise in Safety Net Institutions

In addition to providing large volumes of care generally, safety net hospitals and health systems tend to provide a huge proportion of care to Medicaid, Medicare and uninsured patients in particular. **Over 70 percent of inpatient care provided in NAPH member hospitals in 1995 was for Medicaid and so-called "selfpay" individuals. For safety net institutions, these patients are for the most part medically indigent individuals who cannot afford to pay for the services they receive.**[2] When Medicare patients are added, the proportion jumps to 90 percent. For outpatient and emergency care, the proportion of visits for Medicaid and selfpay individuals was 77 percent (Figure 1).

As safety net providers, NAPH members have historically provided large amounts of uncompensated care in their communities and their share of the uncompensated care burden is steadily increasing. In 1995, 67 hospitals reported incurring $5.8 billion in uncompensated care (defined as bad debt and charity care) for an average of just over $86 million per hospital.

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[1] The 100 largest cities are ranked according to population and defined as central cities, not MSAs. The analysis was conducted using data from the 1994 AHA Annual Survey.

[2] Self-pay patients typically include both uninsured patients who can afford to pay some or all of their hospital bills out-of-pocket, as well as uninsured patients who can or do not. So, for NAPH members, "selfpay" patients are the equivalent of "no-pay" patients.

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For these institutions, bad debt and charity care charges represented a full 25 percent of total gross charges. According to data from AHA, all hospitals nationwide provided $28.1 billion in bad debt and charity care. **While NAPH member hospitals represent less than two percent of hospitals, they provide over 20 percent of bad debt and charity care.**

Moreover, in a trend with sobering implications for safety net institutions, uncompensated care is increasingly concentrated among an ever-shrinking number of providers. AHA data on public general hospitals in the 100 largest cities (a subset of total NAPH members) from 1980 and 1993 indicate that the category of selfpay (or no-pay) patients increased from 16.8 percent of gross charges to 22.2 percent, or an increase of over 30 percent. Among private general hospitals during the same period, the proportion of patients with no insurance decreased from 7.4 percent of gross charges to 5.5 percent, a 26 percent decrease. At the same time, private hospitals' share of Medicaid patients grew by 15 percent, reflecting increasing competition for less costly Medicaid patients, such as healthy pregnant women and children.[3]

Further, the number of uninsured Americans continues to rise. The passage of welfare reform legislation in the last Congress is the single most sweeping rollback in Medicaid coverage since the program's establishment. The bill eliminated Medicaid and Medicare SSI coverage for substantial numbers of legal immigrants, thereby not only significantly increasing the rolls of the uninsured, but placing a particular burden on safety net providers and the state and local governments that support them. Legal immigrants will continue to need medical care in times of sickness or accident, and will seek that care in safety net hospitals who treat all regardless of ability to pay. Many of these hospitals in high immigration states will be overwhelmed by the burden of providing yet more uncompensated care.

Safety Net Providers Depend on Medicaid and Medicare to Finance Uncompensated Care

Unlike most community hospitals that can tap commercial patient revenues to subsidize uncompensated care, urban safety net hospitals rely on Medicare and Medicaid revenues to subsidize the huge amounts of uncompensated care they provide. While Medicaid and Medicare combined represented 55 percent of the overall care provided by NAPH members in 1995, they accounted for 71 percent of net patient revenues.[4]

Appropriations from local government and other revenues intended to cover indigent care costs amounted to 12.3 percent of total revenues. In effect, state and local subsidies cover just over half of the cost of uncompensated care provided at NAPH member hospitals. To make up the difference, these hospitals rely on Medicaid disproportionate share hospital (DSH) payments (40 percent) and Medicare DSH payments (9 percent) (Figure 2). While Medicare DSH payments may not appear significant by comparison, Medicare is a key payer in the fragile partnership of federal/state and local governments that currently finances uncompensated care, particularly in the face of serious proposals to cut Medicaid DSH and declining support by state and local governments (local subsidies have decreased 46 percent over the last eight years). In 1995, 53 NAPH hospitals received a total of $316 million in

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[3] National Public Health and Hospital Institute. Urban Social Health: A Chart Book Profiling the Nation's 100 Largest Cities, Washington, DC:1995.

[4] Since much of the overall care provided by NAPH members (as measured by their "gross revenues") is to uninsured patients who cannot afford to pay for their care, the actual revenues received (as measured by their "net revenues") that is represented by Medicaid and Medicare revenues is higher than the proportion of care provided to these patient populations.

Medicare DSH payments, roughly 8 percent of the $3.8 billion DSH payments nationwide. Medicare DSH has been and will continue to be an essential piece of the patchwork funding that enables NAPH members to provide critical health services to the elderly, disabled and poor.

Medicare Graduate Medical Education Payments Are a Critical Source of Financing Physician Training

NAPH member hospitals play a significant role in training residents and health professionals. Over 85 percent of NAPH members are teaching hospitals, and they trained nearly 18 percent of all residents in 1994. In 1994, 62 NAPH hospitals trained 12,531 residents, or an average of 202.

The Medicare program provides substantial funding for graduate medical education (GME), and is in fact the only payer to make explicit payments for GME (although some state Medicaid programs provide GME payments; this funding totals less than $1 billion annually[5]). As such, adequate Medicare GME payments are critical to support the training of our nation's physicians. In 1995, 63 NAPH members received $158 million in DGME payments from Medicare and nearly double that or $261 million in IME payments. While these payments represent substantial support for training programs, NAPH hospitals receive less GME payments than hospitals with comparably sized teaching programs because they treat fewer Medicare patients.

GME is a Public Good Which Should Be Financed By All Parts of the Health Care System

NAPH supports a "shared responsibility" approach to financing graduate medical education which treats GME as a public good. This approach would require contributions from all payers of health care, not just Medicare, and, thus, should distribute GME funding based on all patient care volume. We support legislation introduced by Senator Moynihan (S.21), which accomplishes this goal. Alternatively a trust fund approach could be financed with general revenue contributions or a broad-based tax.

The level of financing for GME is critical and must be maintained. As other payers negotiate ever lower rates, teaching hospitals are losing their ability to cross-subsidize medical education costs. In addition, as more Medicare patients move to managed care, GME funds, which are currently based on the volume of Medicare fee-for-service patients, will diminish considerably. These trends threaten to undermine the viability of our nation's teaching hospitals and their ability to train physicians.

Proposals to Remove DSH and GME Payments from Medicare Should Be Undertaken with Extreme Care Not to Undermine the Safety Net and Teaching Institutions that These Payment Streams Support

NAPH is concerned with suggestions from both House and Senate members that we examine the possibility of removing DSH and GME payments from Medicare and finance them with

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[5] Diane N. Plumb and T. Henderson, "Medicaid Financing of Graduate Medical Education: A Survey of the States," GWU Intergovernmental Health Policy Project study for the Association of American Medical Colleges, October 1995.

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general revenue funds. In theory, NAPH agrees that providing care to low income populations and training physicians are "public goods" that should be financed by a broader base than just Medicare. However, without having seen any details about how such a move would be implemented, we do have a number of concerns about these suggestions.

First, under the current system DSH and GME are part of the Part A Trust Fund, and as such the funding for them is protected through a dedicated revenue stream. We would certainly be concerned about any approach that did not set up a similar trust fund mechanism and provide protection for these payments similar to that currently accorded them.

Second it is imperative that these payments be adequately funded. At a bare minimum they should receive funding in at least the same amounts as under current law. We would not support any such structural move that had the effect -- intended or otherwise -- of cutting the overall funding for these programs.

Medicare GME and DSH Funds Should Be Carved Out of the AAPCC and Made Directly to Hospitals

The current methodology for distributing DGME, IME and DSH payments is seriously flawed in the Medicare managed care context. For Medicare patients enrolled in managed care, these supplemental payments are incorporated into the average adjusted per capita cost (AAPCC) which is the capitation payment made to managed care plans. The plans do not necessarily pass these payments along to the hospitals which incur the costs that justify the payments. In fact, some plans receive the payments and do not even contract with such hospitals. As Medicare increases the use of capitated risk contracting, the amount of DGME, IME and DSH funds that go to teaching hospitals will diminish considerably unless this payment policy is changed. In essence, payments intended to support the costs of teaching or low income care are being diverted from the hospitals that provide the care to managed care plans that are not fulfilling this mission. For this reason, the GME and DSH payments must be carved out of the AAPCC rate and made directly to the hospitals that incur those costs.

Physician Workforce Reforms Must Be Balanced With Maintaining Access to Care in Underserved Communities

Current Medicare GME financing policy does not address the size or type of physician workforce that hospitals are training. Yet often physician workforce reform proposals are coupled with discussions about reform of medical education. Many policymakers believe that the nation's medical schools and teaching hospitals train too few primary care physicians, too many specialists, and too many physicians overall. Certainly the focus on specialty care, as well as on acute, episodic intervention, as opposed to primary and preventive care, has raised costs and compromised the health status of many communities. Additionally, the medical education system has trained too few minorities and too few doctors willing to practice in underserved communities. The shortage of physicians in these communities in particular requires that policymakers act cautiously in reforming physician workforce policy, because many of our nation's safety net providers rely on residents and supervising attending physicians to provide otherwise unavailable care in these areas. Further, NAPH member systems tend to train more minorities and more physicians who will most likely continue to serve those communities and/or who will have a unique understanding of the needs of vulnerable populations in their private practices

This concern about workforce policy and access to care in safety net hospitals is particularly relevant to two common GME reform initiatives: reducing the number of international medical graduates (IMGs) and changing the mix of primary care and specialty training slots. Most of the growth in resident training positions over the last ten years has been the result of increases in slots for individuals who trained in medical schools outside the U.S., called IMGs. While reducing the number of or financing for IMG slots is often seen as the solution to a perceived over supply of physicians -- and, in fact, was recommended two weeks ago by AAMC, the AMA, and other medical societies -- in the case of safety net hospitals, such proposals could have dire consequences. These residents, supervised by attending physicians, provide a considerable amount of care to low income patients with otherwise limited access to services (Figure 3). Not all safety net hospitals or systems rely heavily on IMGs, however, the phenomenon is not localized in any particular state or region. Replacing these physicians is costly -- NAPH members estimate that it would cost two to three times more to replace a resident with some combination of physicians and non-physician providers -- and difficult, since replacements are not easily found.

The same care should be taken with respect to proposals to limit or reduce the number of specialty training slots or financing for such slots. While we support the expansion of primary care capacity in physician training, specialty residents and fellows in safety net hospitals may be the only physicians available to serve many low income, vulnerable communities -- where no private physicians practice. **NAPH urges that access to care be an important criterion in decisions about reducing or restructuring the physician workforce.**

The Medicare Disproportionate Share Hospital Formula Should Be Changed to Reflect Uncompensated Care And HCFA Should Be Authorized to Begin Collecting The Data to Do So As Soon As Possible.

NAPH supports ProPAC's recommended reform of the Medicare DSH formula to account for uncompensated care. We wholeheartedly endorse the approach they have developed using costs of care for low income populations, and in fact have used it as the basis for our proposed reform of the Medicaid DSH program.

Nevertheless, in order to implement this kind of measure of low income care, additional data collection will be necessary, as ProPAC points out. No accurate or consistent data on hospitals' costs for these populations currently exist in any usable form. While we are in the process of modeling our Medicaid DSH proposal using proxies for some of these costs, it may be desirable for HCFA to do so more systematically in the manner outlined in the ProPAC report. As ProPAC observes, data necessary to develop a reasonably accurate estimate of these costs could be collected with relatively little additional burden on hospitals. Because this information would be invaluable for both Medicare and Medicaid DSH reform, we urge Congress to authorize and direct HCFA to begin collecting such data as soon as possible, without waiting for a Medicare or Medicaid bill to be adopted.

To summarize NAPH's concern about the current DSH formula, it is based on a hospital's "disproportionate share patient percentage," which is a measure of the proportion of care provided to Supplemental Security Income (SSI) and Medicaid patients.

There are a number of serious problems with this formula that warrant reexamination.

- In relying on measures of SSI and Medicaid populations, the statutory low income proxy does not include the significant uncompensated patient care load that some hospitals are currently bearing.[6] This problem will be exacerbated as the impact of welfare reform legislation begins to reduce Medicaid eligibility in states with high numbers of immigrants or in states that choose to de-link Medicaid and welfare eligibility.

- Many hospitals are finding it difficult, if not impossible, to identify Medicaid patients in states that have moved to implement Medicaid managed care -- Medicaid patients show up with an insurance card from a managed care plan, which may not identify them to be Medicaid recipients. To the extent the Medicare DSH formula relies on Medicaid utilization, the inability to account for all Medicaid patients translates into reduced Medicare DSH dollars.

- Hospitals with significant uncompensated care burdens are finding it increasingly difficult to retain their share of the less costly Medicaid populations (for example, healthy mothers and children) as market competition intensifies. Their burden of uncompensated care and care to high risk chronically ill populations is increasing while their ability to cross-subsidize that care with lower risk Medicaid volume is diminishing.

- The DSH formula needs to reflect the change in health care delivery from inpatient to outpatient services. As hospitals reorient to provide more preventive and primary outpatient care and less episodic, acute inpatient care, the DSH formula should include inpatient and outpatient services as part of its measure of low income costs.

For all of these reasons, changing the Medicare DSH low income proxy is imperative to protecting access in hospitals that serve large numbers of low income patients. ProPAC has recognized this need and proposes a change in the low income proxy to include all of the elements of low income care. Their proposed low income cost variable includes Medicare SSI patients, Medicaid patients, care to patients supported by local indigent care programs, and uncompensated care. NAPH strongly supports this approach to incorporating all of the components of low income care and to targeting Medicare DSH funds on the highest volume providers of low income care.

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[6] Uncompensated care is accommodated in the formula only indirectly, because payments are made to hospitals with at least 100 beds that receive at least 30 percent of their net revenues from state or local government payments for indigent care.

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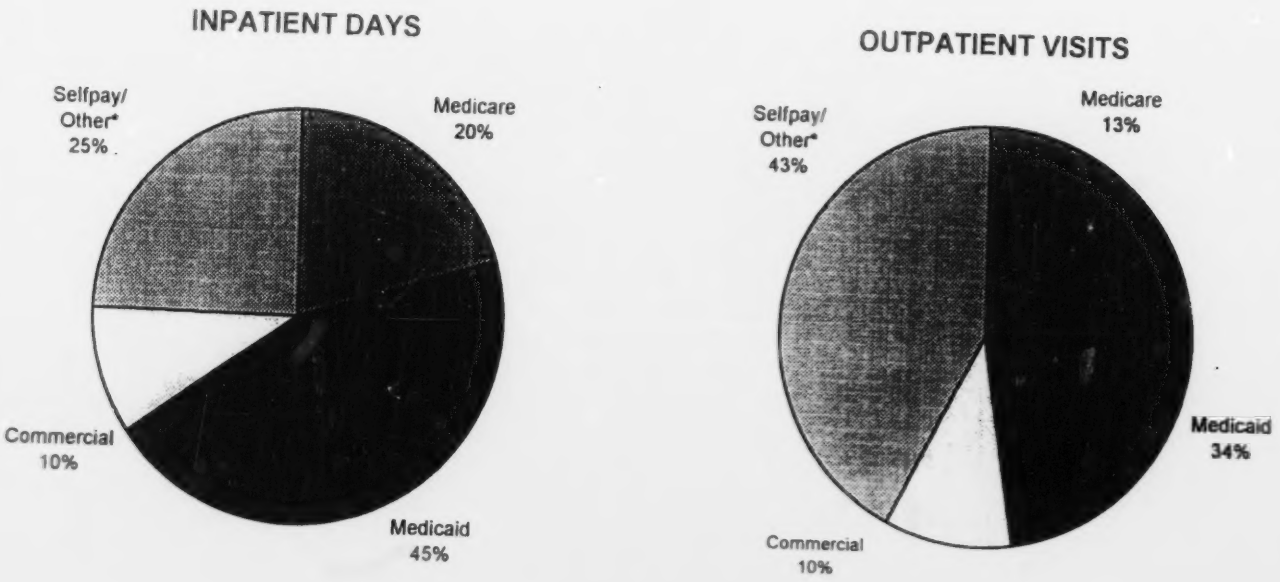
Figure 1

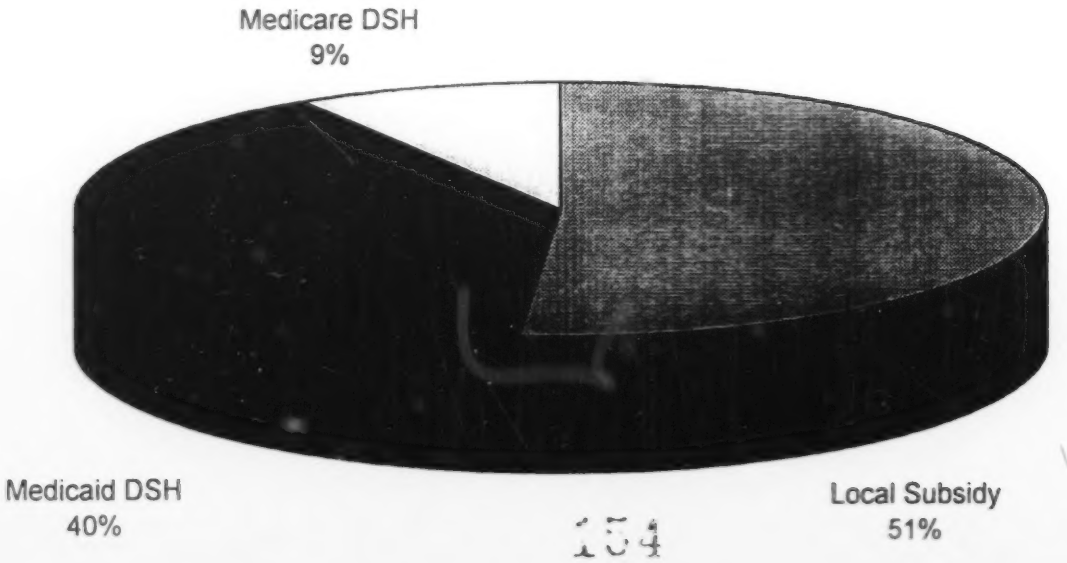
Payer Source for NAPH Member Hospitals, 1995



* Typically, selfpay patients in NAPH member hospitals are the indigent who cannot afford to pay for services.

Figure 2

Sources of Financing of Uncompensated Care for NAPH Members, 1995



Local Subsidy = $1.87 Billion
Medicaid DSH = $1.44 Billion
Medicare DSH = $0.32 Billion

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Figure 3

International Medical Graduates at Select NAPH Member Hospitals

Hospital	City, State	Total Residents	Total IMGs	Percent IMGs	IMGs in Primary Care	IMGs in Specialty Care
Boston Medical Center	Boston, MA	230	46	20%	6%	22%
Hermann Hospital	Houston, TX	451	108	24%	N/A	N/A
Jackson Memorial Hospital	Miami, FL	977	386	40%	47%	34%
LAC-King/Drew Medical Center	Los Angeles, CA	303	139	46%	N/A	N/A
LHCA-Medical Center of Louisiana at New Orleans	New Orleans, LA	1,144	69	6%	N/A	N/A
Maricopa Health System	Phoenix, AZ	265	53	20%	N/A	N/A
MetroHealth System	Cleveland, OH	315	126	40%	39%	39%
NYCHHC-Harlem Hospital Center	New York, NY	329	195	59%	74%	45%
NYCHHC-Lincoln Hospital and Mental Health Center	Bronx, NY	328	258	79%	100%	60%
NYCHHC-Metropolitan Hospital Center	New York, NY	247	193	78%	95%	63%
NYCHHC-Woodhull Hospital and Mental Health Center	Brooklyn, NY	120	120	100%	100%	100%
Parkland Health and Hospital System	Dallas, TX	444	58	13%	N/A	N/A
San Francisco General Hospital	San Francisco, CA	202	10	5%	4%	5%
Tampa General Healthcare	Tampa, FL	185	37	20%	26%	12%
Thomason General Hospital	El Paso, TX	154	86	56%	39%	16%
UMDNJ-University Hospital	Newark, NJ	563	257	46%	61%	42%
University Medical Centerof Southern Nevada	Las Vegas, NV	100	36	36%	62%	7%
University of TexasMedical Branch	Galveston, TX	571	139	24%	N/A	N/A
TOTAL		6,928	2,316	33%		

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STATEMENT TO THE SENATE FINANCE COMMITTEE ON GRADUATE MEDICAL EDUCATION REFORM

THE NATIONAL LEAGUE FOR NURSING

MARCH 27, 1997

The National League for Nursing (NLN) is a membership organization representing individuals and agencies promoting quality in health professions education and health care services. NLN has 46 constituent leagues nationwide, comprised of over 18,000 nurses, other health professionals, educators, researchers, administrators, and consumers. Members also include 2,000 academic nursing education programs, home care and community health agencies, and nursing departments in hospitals and related facilities. NLN accredits schools of nursing, and its nursing education program members represent all levels of nursing education.

NLN appreciates the Committee's longstanding recognition of the need to provide support for the costs incurred in the provision of graduate medical education (GME). We also appreciate the Committee's recognition that the time to address needed reforms in GME is overdue. Our health care system is changing significantly, and the nature of our support for GME must change as well if we are to have the health care workforce that we need.

The reasons reform is needed fall into three broad categories:

- The health care delivery system's evolution to managed care has increased the trend towards primary and community-based care, exacerbating the imbalance between specialty and primary care physicians, and increasing the need for other health professionals, such as nurse practitioners and advanced practice nurses.

- Scientific advancements, in combination with marketplace changes, have accelerated health care's shift from inpatient to outpatient and community-based care, making an inpatient hospital-based teaching model increasingly anachronistic.

- Sources of support for GME are declining, as payers in an increasingly price sensitive marketplace are unwilling to pick up these costs, leaving only Medicare as the bulwark of GME financing.

NLN joins with the American Association of Medical Colleges and others in support of a broader-based financing mechanism for graduate medical education

such as proposed in two innovative approaches in the 104th Congress -- the Teaching Hospital and Graduate Medical Education Trust Fund included in the Balanced Budget Act of 1995 (H.R.2491)and the Medical Education Trust Fund Act of 1996 (S. 1870), introduced by Senator Daniel PatricK Moynihan (D-NY) and reintroduced this year as S.21.

At the same time, we urge the Committee to continue its consideration of more effective targeting of Medicare's GME dollars. While Medicare should reimburse hospitals for a portion of their teaching costs, the current GME payment methodology must be reformed to reflect the recent and dramatic shifts in where and how health care is delivered, changes which are only accelerating. GME reform must recognize the need to support teaching costs in all settings, given the move to increased primary and community-based care. And, it must incorporate all health professionals carrying the responsibility for managing patients' primary and community-based care.

One example is the advanced practice nurse (APN), a category which includes nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists. APNs are educated in graduate nurse education (GNE) programs accredited by nationally and regionally recognized accrediting bodies. There is a need to produce sufficient supplies of advanced practice nurses to meet the workforce requirements of our current and future health system, particularly for Medicare beneficiaries, with their increased need for more chronic and community-based services.

The Institute of Medicine (IOM), in a recent report on nurse staffing in hospitals and nursing homes, urged that increasing numbers of registered nurses with advanced practice skills be utilized in outpatient and inpatient settings to meet the demand for RNs with management, leadership, and supervisory abilities. The panel noted that advanced practice nurses not only provide high-quality and cost-effective care, especially for patients with complicated or serious clinical conditions such as Medicare patients, but they are also well-skilled for the sophisticated levels of practice required in today's hospitals. IOM also recommended that nursing home care be enhanced through the increased presence of gerontological nurse specialists and nurse practitioners.

Most categories of APNs were not in existence when Medicare educational payment policies were designed. Although Medicare's contribution (out of an over $7 billion GME program) to the direct clinical training costs of registered nurses is an estimated $244 million in 1996 and will be a projected $420 million in the year 2000, the program provides no support for APNs, with the exception of nurse anesthetists. At the present, the Medicare reimbursement for nursing clinical education programs is limited by the "provider-operated rule", which directs most of the funding to hospitals that operate diploma programs, with some support for baccalaureate programs with school/provider agreements.

NLN recommends that Medicare's reimbursement eligibility requirements for nursing be changed to include "jointly -operated" (provider-academic) programs that incur direct clinical costs for graduate advanced practice nurse education. We also recommend that reimbursement allow for support of clinical training costs in community-settings as well as hospital-based settings. APN programs should be given priority for Medicare nurse education financing, reflecting their need.

This support is essential to our ability to provide an adequate supply of APNs. A 1995 Lewin-VHI study ("Expanding the Capacity of Advanced Practice Nursing Education-Final Report") found that the availability of sites for appropriate clinical education, and preceptors, is the single most significant factor in determining an APN program's ability to expand. Programs are competing with physicians and other health professionals for training slots that are becoming increasingly limited due to the effects of managed care and a competitive, cost-conscious marketplace.

The APN is a vital member of the health care team needed to maintain and improve access to quality health care services for Medicare beneficiaries in a rapidly changing health care environment. This is the time to reform Medicare GME, and one essential reform is to allow Medicare direct medical eduction support for advanced practice nurses.

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